Dear Options Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2003 Certificate of Coverage booklet. It explains the services and benefits you and those enrolled on your contract are entitled to receive from Group Health Options, Inc. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health Options, Inc. for your healthcare coverage.

Certain words, paragraphs, and sections of this certificate have been bolded and italicized. This identifies changes Group Health Options, Inc. has made to the plan, or corrects or clarifies language to more accurately reflect Group Health Option's current administrative or care delivery practices. In addition, other benefit or contract provisions that your employer or association might have requested or negotiated are included in this certificate.

We urge you to read it carefully, so you'll understand not only the benefits, but the exclusions, limitations and eligibility requirements of this certificate. Please keep this certificate for as long as you are covered by Group Health Options, Inc. We will send you revisions if there are any changes in your coverage.

This certificate is not the contract itself; you can contact your employer or group administrator if you wish to see a copy of the contract (Medical Coverage Agreement).

We'll gladly answer any questions you might have about your Options benefits. Please call our Options Information Line at 206-901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Thank you for choosing Options. We look forward to working with you to preserve and enhance your health.

Sincerely,

Maureen McLaughlin
President and Chief Executive Officer

CA-416a02

Certificate of Coverage

Group Health Options, Inc. (also referred to as "GHO") is a Health Care Services Contractor, duly registered under the laws of the State of Washington.

Read Your Certificate Carefully

This Certificate of Coverage is a statement of benefits, exclusions, payments and other provisions as set forth in the Group Medical Coverage Agreement between Group Health Options, Inc., also referred to as GHO, and your employer or Group. Some of the provisions of the Group Medical Coverage Agreement are abridged in this Certificate of Coverage.

Accessing Care

MEMBERS HAVE THE OPTION OF RECEIVING SERVICES EITHER:

- From a Managed Health Care Network, hereinafter referred to as "MHCN," in this case Group Health Cooperative; or
- From Community-based Providers or Preferred Community Providers on a self-referred basis.

Members may choose either health care delivery option at any time during or for differing episodes of illness or injury except during a scheduled inpatient admission.

The level of benefits available under this agreement for services received at or upon referral by the MHCN is greater than for services received from community-based providers. ***In order for services to be covered at the higher benefit level, services must be obtained by MHCN providers at MHCN Facilities.***

Except as follows:

- ***Emergency care,***
- ***self-referral to women's MHCN health care providers,***
- ***visits with MHCN Designated Self-Referral Specialists as set forth below,***
- ***other services as specifically set forth in the Allowances Schedule and Section XII.,***
- ***care provided pursuant to a Referral. Referrals must be requested by the Member's MHCN Primary Care Provider and approved by GHO.***

Primary Care. Members must select a MHCN Primary Care Provider when enrolling under this Agreement. One primary care provider may be selected for the entire family, or a different primary care provider may be selected for each family member. If the primary care provider is not selected at the time of enrollment, Group Health Options will assign a primary care provider, and a letter of explanation and an identification card will be sent to the Member.

Selecting a primary care provider or changing from one Primary Care Provider to another ***can be accomplished by*** contacting Group Health Options Customer Service, ***or accessing the GHO website at www.ghc.org.*** The change will be made within twenty-four (24) hours of the receipt of the request if the selected physician's caseload permits.

A listing of MHCN Primary Care Providers, referral specialists, women's health care providers, and MHCN Designated Self-Referral Specialists is available by contacting GHO Customer Service at (206) 901-4636 (or 1-888-901-4636), or by accessing GHO's website at www.ghc.org.

In the case that the Member's primary care provider no longer participates in the MHCN, the Member will be provided a written notice offering the Member a selection of new primary care providers from which to choose.

Specialty Care. Unless otherwise indicated in this section, the Allowances Schedule, or Section XII., referrals are required for specialty care and specialists inside the network.

MHCN Designated Self-Referral Specialist. Members may make appointments directly with MHN-Designated Self-Referral Specialists at Group Health-owned or operated medical centers without a Referral from their primary care provider. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health,

nephrology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy*, smoking cessation, speech/language and learning services*, and urology.

****Medicare patients need a Referral for these specialists.***

Women's Health Care Direct Access Providers. Female Members may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Licensed Midwife, Doctor of Osteopathy, Pediatrician, Obstetrician ***or*** Advanced Registered Nurse Practitioner who is contracted to provide women's health care services directly, without a Referral from their Primary Care Provider, for Medically Necessary and appropriate maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care, and medically appropriate follow-up visits for the above services. ***Within the network,*** women's health care services are covered as if your Primary Care Provider had been consulted, subject to any applicable Copayments and/or Coinsurance as set forth in the Allowances Schedule. ***Outside the network, self-referral for women's health care services are available at the community provider benefit level.*** If your women's health care provider diagnoses a condition that requires referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with GHO requirements.

Second Opinions. The Member may access, upon request a second opinion regarding a medical diagnosis or treatment plan from a MHCN Provider. The Member may also access a second opinion from a Community Provider, subject to the out-of-network benefit level.

Emergent and Urgent Care. Emergent and urgent care services are covered as set forth in Section XII.L. Contact the Emergency Notification Line as indicated on your GHO identification card.

Benefits paid under one option will not be duplicated under the other option.

Recommended Treatment. Under the managed care option, GHO's Medical Director, or his/her designee will determine the necessity, nature, and extent of treatment to be covered under the MHCN benefit in each individual case and the judgment, made in good faith, will be final. Coverage decisions may be appealed as set forth in Section VIII.

Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended treatment or diagnostic plan to the extent permitted by law. In such case, GHO shall have no obligation to provide care not recommended by GHO's Medical Director, or his/her designee, under the MHCN option.

Major Disaster or Epidemic.

Under the managed care option, in the event of a major disaster or epidemic, GHO will provide coverage through the MHCN according to its best judgment and within the limitations of available MHCN Facilities or MHCN Designated Facilities and personnel. GHO has no liability for delay or failure to provide or arrange Covered Services to the extent facilities or personnel are unavailable due to a major disaster or epidemic.

Under the Community Provider option, in the event of a major disaster or epidemic, GHO will provide coverage through Community providers and non-MHCN Facilities according to its best judgment within the limitations of such Community Providers, and non-MHCN Facilities and personnel. GHO has no liability for delay or failure to provide or arrange Covered Services to the extent facilities or personnel are unavailable due to a major disaster or epidemic.

Unusual Circumstances.

Under the managed care option, if the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as complete or partial destruction of MHCN facilities, military action, civil disorder, labor disputes, or similar causes, GHO shall make a good faith effort to make the then-existing MHCN facilities and personnel available. GHO shall ensure that its MHCN provide and arrange for services that, in the reasonable opinion of GHO's Medical Director, or his/her designee, are emergent or urgently needed. The MHCN shall have the option to defer or reschedule services that are not urgent while its facilities and services are so affected.

Under the Community Provider option, if the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as military action, civil disorder, labor disputes, or similar causes, in no case shall GHO have any liability or obligation on account of delay.

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ALLOWANCES SCHEDULE

MHCN	**WHEN CARE IS PROVIDED BY A MHCN PROVIDER OR REFERRED BY A MHCN PRIMARY CARE PROVIDER**
COMMUNITY PROVIDER	**WHEN CARE IS OBTAINED FROM A COMMUNITY PROVIDER OR PREFERRED COMMUNITY PROVIDER ON A SELF-REFERRED BASIS.** Coverage is limited to the Preferred Community Provider Contracted Rate or Usual, Customary and Reasonable charges, less any applicable Deductible and Coinsurance amounts as noted below.

THE BENEFITS DESCRIBED IN THIS SCHEDULE ARE SUBJECT TO ALL PROVISIONS, LIMITATIONS AND EXCLUSIONS SET FORTH IN THE GROUP MEDICAL COVERAGE AGREEMENT.

ANNUAL DEDUCTIBLE

Individual/Family initial annual Deductible

MHCN: No annual Deductible.

COMMUNITY PROVIDER: Annual Deductible of $200 per Member or $400 per Family Unit per calendar year. Annual Deductible does not apply to Stop Loss.

PLAN COINSURANCE

MHCN: No plan Coinsurance.

COMMUNITY PROVIDER: 80% of the Preferred Community Provider Contracted Rate or Usual, Customary and Reasonable charges are covered.

LIFETIME MAXIMUM

No lifetime maximum ***unless otherwise indicated***.

HOSPITAL *SERVICES*

- ***Covered inpatient services [medical and surgical services, including acute chemical withdrawal (detoxification)]***

MHCN: Covered in full.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance, after the annual Deductible is satisfied. Preauthorization is required for scheduled admissions as set forth in Section XII.A.

- ***Covered outpatient hospital surgery (including ambulatory surgical centers)***

MHCN: Covered in full.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

OUTPATIENT SERVICES

- ***Covered outpatient medical and surgical services***

MHCN: $15 Copayment per visit per Member.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- ***Allergy testing***

MHCN: Covered subject to the outpatient services Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- ***Oncology (radiation therapy, chemotherapy)***

MHCN: Covered subject to the outpatient services Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

DRUGS - OUTPATIENT (INCLUDING MENTAL HEALTH DRUGS, CONTRACEPTIVE DRUGS AND DEVICES AND DIABETIC SUPPLIES)

- ***Prescription drugs, medicines, supplies and devices for a supply of 30 days or less when listed in the GHO drug formulary***

MHCN: Covered for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider, subject to the lesser of the MHCN's charge or a $10 Copayment for generic drugs or $15 Copayment for brand name drugs.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance. Coinsurance does not apply to Stop Loss.

- ***Over-the-counter drugs and medicines***

Not covered.

- ***Allergy Serum***

MHCN: Covered in full.

COMMUNITY PROVIDER: Covered subject to the prescription drug copayment or the plan Coinsurance, whichever is greater, for each 30-day supply.

- ***Injectables***

Injections that can be self-administered are subject to the prescription drug Copayment.

Mail order drugs and medicines

MHCN: Maintenance drugs, which require a prescription when provided at MHCN Facilities and prescribed by a MHCN Provider for a supply of ninety (90) days or less of an outpatient prescription or refill, is covered subject to the lesser of the MHCN's charge or a $10 Copayment for generic drugs or $15 Copayment for brand name drugs.

COMMUNITY PROVIDER: Not covered.

- **Growth Hormones** ***(subject to a 12 month waiting period)***

MHCN: Covered in full.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

***OUT-OF-POCKET LIMIT (*STOP LOSS)**

MHCN: ***Except as otherwise noted in this Allowances Schedule,*** Out-of-Pocket Expenses for Covered Services (as set forth below) are limited to an aggregate maximum of $650 per Member and $1,300 per Family Unit per calendar year.

- Inpatient Services
- Outpatient Services
- Emergency Care at a MHCN, or MHCN Designated Facility
- Ambulance services

COMMUNITY PROVIDER: ***Except as otherwise noted in this Allowances Schedule,*** Out-of-Pocket Expenses for Covered Services (as set forth below) are limited to an aggregate maximum of $750 per Member and $1,500 per Family Unit per calendar year, after which the plan Coinsurance no longer applies.

- Plan Coinsurance
- Emergency Care at a non-MHCN Facility

ACUPUNCTURE

MHCN: Self-referrals to a MHCN Provider covered up to a maximum of five (5) visits per Member per medical diagnosis per calendar year, subject to the outpatient services copayment. Additional visits are covered when approved by GHO subject to the outpatient services copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

AMBULANCE SERVICES

Emergency ground/air transport

MHCN: Transport to a MHCN or MHCN Designated Facility is covered at 80%.

COMMUNITY PROVIDER: Transport to a non-MHCN Facility is covered at 80%. Coinsurance does not apply to the annual Deductible or Stop Loss.

- ***Non-emergent transfer***

MHCN: MHCN-initiated transfers to a MHCN or MHCN Designated Facility from a non-MHCN Facility ***are*** covered in full.

COMMUNITY PROVIDER: When Medically Necessary and prescribed by the attending physician, transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered at 80%.

CHEMICAL DEPENDENCY TREATMENT

Inpatient Services

MHCN: Covered subject to the applicable inpatient Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

Outpatient Services

MHCN: Covered subject to the applicable outpatient ***services*** Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

Benefit Period Allowance

MHCN: ***$11,285*** maximum per Member per any 24 consecutive calendar month period.

COMMUNITY PROVIDER: ***$11,285*** maximum per Member per any 24 consecutive calendar month period.

Acute detoxification covered as any other medical service. Not subject to 24 month maximum.

DENTAL SERVICES (including accidental injury to natural teeth)

Not covered.

DEVICES, EQUIPMENT AND SUPPLIES *(for home use)*

- Durable medical equipment listed as covered in the durable medical equipment formulary
- Prosthetic devices listed as covered in the prosthetic device formulary
- Orthopedic appliances
- Ostomy supplies
- Oxygen and oxygen equipment
- Post-mastectomy bras (limited to two every 6 months)

MHCN: Covered in full. Orthopedic appliances are covered when listed as covered in the orthopedic appliance formulary.

COMMUNITY PROVIDER: Covered at 100% after the annual Deductible is satisfied.

DIABETIC SUPPLIES

MHCN: Insulin, needles, syringes and lancets covered under Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies covered under Devices, Equipment and Supplies. Blood glucose monitoring reagents & urine testing reagents are covered in full.

COMMUNITY PROVIDER: Insulin, needles, syringes and lancets covered under Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies covered under Devices, Equipment and Supplies. Blood glucose monitoring reagents & urine testing reagents are covered subject to the plan Coinsurance.

DIAGNOSTIC LABORATORY AND RADIOLOGY SERVICES

MHCN: Covered in full.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

EMERGENCY SERVICES

- ***At a MHCN or MHCN Designated Facility***

MHCN: $15 Copayment per Emergency visit per Member. Copayment is waived if Member is admitted to the hospital directly from the emergency department.

- ***At a non-MHCN Facility***

COMMUNITY PROVIDER: UCR charges are covered, subject to a $65 Deductible or total charge of services, whichever is less.

The Emergency care Deductible is not waived if the Member is admitted to the hospital. The Member must notify GHO within 24 hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered under the MHCN level of benefits. If the Member does not notify GHO within 24 hours following admission, or declines to have care managed by the MHCN, all inpatient services are covered subject to the plan Coinsurance after the annual Deductible is satisfied.

HEARING EXAMINATIONS AND HEARING AIDS

MHCN: Hearing examinations to determine hearing loss are covered subject to the outpatient ***service*** Copayment. Hearing aids, including hearing aid examinations, are covered up to a maximum of $400 per ear limited to one aid per ear during a period of three (3) consecutive years.

COMMUNITY PROVIDER: Hearing examinations to determine hearing loss are covered subject to the plan Coinsurance after the annual Deductible is satisfied. Hearing aids, including hearing aid examinations, are covered up to a maximum of $400 per ear limited to one aid per ear during a period of three (3) consecutive years.

HOME HEALTH *SERVICES*

MHCN: Covered in full. .No visit limit.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

HOSPICE SERVICES

MHCN: Covered in full. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence. Preauthorization is required for scheduled Hospice admissions (See Section XII.A.).

INFERTILITY SERVICES, (Including sterility)

Not covered.

MANIPULATIVE THERAPY

MHCN: Self-referrals ***to a MHCN Provider for manipulative therapy of the spine*** covered in accordance with ***GHO clinical criteria*** up to a maximum of ten (10) visits per Member per calendar year, subject to the outpatient ***services*** Copayment when provided by an MHCN Provider. Additional ***manipulation*** visits ***are covered when approved GHO***.

COMMUNITY PROVIDER: Covered ***for manipulative therapy of the spine*** up to a maximum of ten (10) visits per Member per calendar year, subject to the plan Coinsurance after the annual Deductible is satisfied.

MATERNITY *AND PREGNANCY SERVICES*

- **Delivery and associated hospital care**

MHCN: Covered subject to applicable inpatient Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- **Routine prenatal and postpartum care**

MHCN: Covered subject to the outpatient ***services*** Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- ***Pregnancy termination***

MHCN: Involuntary/voluntary termination of pregnancy is covered subject to applicable Copayment.

COMMUNITY PROVIDER: Involuntary/voluntary termination of pregnancy is covered subject to the plan Coinsurance after the annual Deductible is satisfied.

MENTAL HEALTH SERVICES

Inpatient Services:

MHCN: Covered at 80% up to twelve (12) days per Member per calendar year. ***Coinsurance does not apply to Stop Loss.***

COMMUNITY PROVIDER: UCR charges covered up to twelve (12) days per Member per calendar year subject to the plan Coinsurance, after the annual Deductible is satisfied. Coinsurance does not apply to Stop Loss.

Outpatient Services:

MHCN: Twenty (20) visits covered per Member per calendar year, subject to a $20 Copayment per individual/family/couple visit and a $10 Member per group session; no coverage after twenty (20) visits per calendar year. ***Copayments do not apply to Stop Loss.*** Medication monitoring visits are subject to the ***outpatient services*** Copayment.

COMMUNITY PROVIDER: Covered at 50% of UCR charges up to twenty (20) visits per Member per calendar year after the annual Deductible has been satisfied; no coverage after twenty (20) visits per calendar year. Coinsurance does not apply to Stop Loss.

NATUROPATHY

MHCN: Self-referrals to a MHCN Provider covered up to a maximum of two (2) visits per Member per medical diagnosis per calendar year, subject to the outpatient services copayment. Additional visits are covered when approved by GHO subject to the outpatient services copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

NUTRITIONAL *SERVICES*

- ***PKU Supplements***

MHCN: Covered in full.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- ***Enteral therapy (formula)***

MHCN: Elemental and enteral formulas covered at 80%. Necessary equipment and supplies covered under Devices, Equipment and Supplies.

COMMUNITY PROVIDER: Covered subject to the annual Deductible and plan Coinsurance. Necessary equipment and supplies covered under Devices, Equipment and Supplies.

- ***Parenteral therapy (total parenteral nutrition)***

MHCN: Covered in full. Necessary equipment and supplies covered under Devices, Equipment and Supplies.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied. Necessary equipment and supplies covered under Devices, Equipment and Supplies.

OBESITY RELATED SERVICES

MHCN: Bariatric surgery covered subject to applicable Copayment. Weight loss programs and medications**,** and related physician visits for medication monitoring**,** are not covered.

COMMUNITY PROVIDER: Not covered, including weight loss programs and medications**,** and related physician visits for medication monitoring.

ON THE JOB INJURIES AND ILLNESSES

Not covered, including injuries or illnesses incurred as a result of self employment.

OPTICAL *SERVICES*

EYE EXAMINATIONS

MHCN: Routine eye examinations are covered subject to the ***outpatient service*** copayment, once every 12 months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the ***outpatient service*** copayment as often as Medically Necessary.

COMMUNITY PROVIDER: Routine eye examinations and refractions are covered once every 12 months up to $30 of Usual, Customary and Reasonable charges.

LENSES AND FRAMES

Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting are covered up to $150 per 24 month period, per Member. The benefit period begins on the date services are first obtained and continues for 24 months.

Contact lenses for eye pathology, including following cataract surgery, are covered in full.

ORGAN TRANSPLANTS

Lifetime Benefit Maximum: $200,000

MHCN: Covered subject to applicable Copayments.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance, after the annual Deductible is satisfied.

PLASTIC AND RECONSTRUCTIVE SERVICES (PLASTIC SURGERY, COSMETIC SURGERY)

MHCN: Surgery to correct a congenital disease or anomaly, or ***conditions resulting from*** injury or incidental to surgery, ***covered*** subject to the applicable Copayment. Cosmetic surgery, including complications, is excluded.

COMMUNITY PROVIDER: Surgery to correct a congenital disease or ***conditions resulting from*** anomaly, or injury or incidental to surgery, ***covered*** subject to the plan Coinsurance after the annual Deductible is satisfied. Cosmetic surgery, including complications, is excluded.

PODIATRIC *SERVICES*

- ***Medically Necessary foot care***

MHCN: Covered subject to the applicable Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- ***Foot care (routine)***

Not covered except in the presence of a non-related medical condition affecting the lower limbs.

PRE-EXISTING CONDITION

Covered, with no wait.

PREVENTIVE (*well adult and well child*) SERVICES (PHYSICALS, IMMUNIZATIONS, PAP SMEARS, WELL-CARE, MAMMOGRAMS)

MHCN: Covered in full. Eye refractions are not included under preventive care. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with preventive care criteria are subject to the outpatient services Copayment.

COMMUNITY PROVIDER: Covered to a maximum of $150 per Member ($300 per Family Unit) per calendar year, subject to the plan coinsurance. Routine mammography services covered subject to plan Coinsurance after the annual deductible is met. Copayment/Coinsurance does not apply to Stop Loss. Excluded are physicals for travel, employment, insurance, license, etc.

REHABILITATION SERVICES

- Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under, plus associated hospital services for the purpose of rehabilitation is covered up to 60 days per condition per calendar year.

MHCN: Covered subject to the applicable inpatient Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under are covered up to 60 visits per condition per calendar year.

MHCN: Covered subject to the applicable outpatient ***services*** Copayment.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

SEXUAL DYSFUNCTION SERVICES

Not covered.

SKILLED NURSING FACILITY (SNF)

MHCN: Covered up to sixty (60) days per Member per calendar year.

COMMUNITY PROVIDER: Covered up to sixty (60) days per Member per calendar year, subject to the plan Coinsurance after the annual Deductible is satisfied.

Preauthorization is required for scheduled admissions (See Section XII.A.).

STERILIZATION (VASECTOMY, TUBAL LIGATION)

MHCN: Covered subject to applicable Copayments.

COMMUNITY PROVIDER: Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

TEMPOROMANDIBULAR JOINT (TMJ) SERVICES

- **Inpatient and outpatient TMJ Services**

MHCN: $1,000 maximum per Member per calendar year, subject to applicable Copayments.

COMMUNITY PROVIDER: $1,000 maximum per Member per calendar year subject to the annual Deductible and plan Coinsurance.

- **Lifetime Maximum Benefit**

MHCN: $5,000 per Member.

COMMUNITY PROVIDER: $5,000 per Member.

TOBACCO CESSATION

Individual/group sessions:

MHCN: Covered at 100% of the total charges.

COMMUNITY PROVIDER: Not covered.

Approved pharmacy products:

MHCN: Covered subject to the lesser of the MHCN's charge or the prescription drug copayment for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN pharmacy.

COMMUNITY PROVIDER: Not covered.

Enrollment/Eligibility Requirements

EFFECTIVE DATE OF ENROLLMENT.

a. Provided application ***for enrollment*** is made as set forth in Section XI.A.1.b.,

- Enrollment for a newly eligible Subscriber and listed Dependents will begin on the date of hire provided payment of applicable premium has been received.

- Enrollment for newly dependent persons, other than newborns and adoptive children, will begin on the first (1st) of the month following application and payment of applicable premium.

- ***Enrollment for*** newborns is effective from the date of birth.

- ***Enrollment for*** adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption and the Subscriber has assumed financial responsibility for the medical expenses of the child.

b. ***Commencement of Benefits for*** **Persons Hospitalized on Effective Date.** Members who are admitted to an inpatient facility prior to their enrollment under this Agreement, and who do not have coverage under another Agreement, will ***receive covered benefits*** beginning on their effective date. If a Member is hospitalized in a non-MHCN Facility or non-MHCN Designated Facility, ***GHO*** reserves the right to require transfer of the Member to a MHCN Facility ***or MHCN Designated Facility***. Such transfer will be made upon consultation with the attending physician and a MHCN Provider. If the Member refuses to transfer to a MHCN Facility ***or MHCN Designated Facility***, and remains in the non-MHCN Facility or non-MHCN Designated Facility, all services received will be covered as set forth in the Allowances Schedule under the Inpatient Hospital Services section of the Community Provider option.

ELIGIBILITY

In order to be accepted for enrollment and continuing coverage under the Group Agreement, individuals must reside or work in the Service Area and meet all applicable requirements set forth below, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents, or when approved in advance by GHO, other unique family arrangements. The Group is responsible for determining eligibility.

1. **Subscribers.** Bona fide employees who are employed on a regularly scheduled basis of not less than eighty (80) hours in a calendar month shall be eligible for enrollment.

2. Family Dependents. The Subscriber may enroll any of the following:

a. The Subscriber's legal spouse;

b. Unmarried dependent children who are under the age of twenty-three (23), provided they reside regularly with the Subscriber or are chiefly dependent on the Subscriber for support and maintenance, provided proof of such dependency is furnished to GHO.

"Children" means the children of the Subscriber including adopted children, stepchildren, foster children, children for whom the Subscriber has a qualified court order to provide coverage, and any other children for whom the Subscriber is the legal guardian.

Unmarried dependents under age twentyt-three (23) may not be in the military, employed full-time and or eligible for any group medical plan through their employer. Coverage for dependents cannot be added or reinstated after age twenty-three (23).

c. Enrollment may be extended past the limiting age for an unmarried person enrolled as a Family Dependent on his/her twenty-third (23rd) birthday if:

i. the Dependent is a full-time registered student at an accredited secondary school, college, or university; or
ii. the Dependent is totally incapable of self-sustaining employment because of a developmental disability or a physical handicap incurred prior to attainment of the limiting age as set forth in 2.b. above, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a dependent child may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity

and proof of financial dependency must be furnished to GHO upon request, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age.

d. **Temporary Coverage for Newborns.** ***When a Member gives birth, the newborn*** will be entitled to the benefits set forth in Section XII. from birth through three (3) weeks of age. After three (3) weeks of age, no benefits are available unless the newborn child qualifies as a dependent and is enrolled under this Agreement. All contract provisions, limitations, and exclusions will apply except Section IV. Continuation of Coverage, Conversion, and Transfer.

CONTINUATION OF ENROLLMENT

While on a group approved leave of absence the Subscriber and listed Dependents can continue to be covered under this Agreement provided they remain eligible for coverage, such leave is in compliance with the employer's established leave of absence policy consistently applied to all employees, the employer's leave policy is in compliance with the Family and Medical Leave Act when applicable, and the employer or Group continues to remit premiums for the Subscriber and Dependents to GHO.

Ineligible Persons. GHO reserves the right to refuse enrollment to any person whose coverage under any Medical Coverage Agreement issued by Group Health Options, Inc. or Group Health Cooperative, has been terminated for cause. (See Section III.B.2. Termination.)

LOSS OF ELIGIBILITY

If a Member no longer meets the eligibility requirements as set forth in the Enrollment/Eligibility Requirements, enrollment under this Agreement shall terminate as of midnight on the date of termination.

Section I. Definitions

AGREEMENT: This Medical Coverage Agreement, including Schedule of Benefits, Enrollment and Eligibility Requirements, Premium Schedule and Allowances Schedule***, and Group Master Application.***

ALLOWANCE: The maximum amount payable by GHO for certain Covered Services under this Agreement, as set forth in the Allowances Schedule.

ANNUAL ENROLLMENT PERIOD: An annual period, jointly specified by the Group and GHO, during which an eligible person may apply for coverage.

CHEMICAL DEPENDENCY: An illness characterized by a physi ological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted.

COINSURANCE: An amount the Member is required to pay for Covered Services received under this Agreement, which is a percentage of the Allowance for such services, as set forth in the Allowances Schedule.

COMMUNITY PROVIDER: Physicians licensed under 18.71 or 18.57 RCW, registered nurses licensed under 18.88 RCW, midwives licensed under 18.79 RCW, naturopaths licensed under 18.36A RCW, acupuncturists licensed under 18.06 RCW, and podiatrists licensed under 18.22 RCW to the extent they provide a service or treat Members within the scope of their licenses. For purposes of this Agreement, Community Providers do not include individuals employed by or under contract with the MHCN (except for Preferred Community Providers). If the provider is under contract with the MHCN and the services have not been authorized in advance by the MHCN, the practitioner is considered a Community Provider.

COPAYMENT: The specific dollar amount required to be paid by a Member for certain Covered Services that are not fully prepaid under this Agreement as set forth in the Allowances Schedule.

COVERED SERVICES: The services for which a Member is entitled ***to coverage*** under this Agreement, which are not otherwise excluded or limited. Covered Services for Out-of-Pocket expenses under the Community Provider are subject to UCR charges.

DEDUCTIBLE: A specific amount that must be paid by the Subscriber or Member for certain Covered Services before benefits for those services are payable under this Agreement. The applicable Deductible amounts are set forth in the Allowances Schedule.

EMERGENCY: The sudden, unexpected onset of a medical condition that in the reasonable judgment of a prudent person is of such a nature that failure to render immediate care by a licensed medical provider would place the Member's life in danger, or cause serious impairment to the Member's health.

FAMILY DEPENDENT: Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder, and for whom the premium prescribed in the Premium Schedule has been paid.

FAMILY UNIT: A Subscriber and all his/her Family Dependents.

FEE SCHEDULE: A fee-for-service schedule adopted by the contracting MHCN, setting forth the fees for the MHCN medical and hospital services.

GROUP: An employer, union, welfare trust, or bona-fide association which has entered into a Group Medical Coverage Agreement with GHO.

HOSPITAL CARE: Those Medically Necessary services generally provided by acute general hospitals for admitted patients. Hospital Care does not include convalescent or custodial care.

MANAGED HEALTH CARE NETWORK (MHCN): The participating provider with which Group Health Options, Inc. has entered into a written participating provider agreement for the provision of Covered Services (under Section XII. Schedule of Benefits). GHO's participating provider is Group Health Cooperative.

MEDICAL CONDITION: A medical condition is a disease, an illness or an injury.

MEDICALLY NECESSARY: Appropriate and necessary services, as determined by GHO's Medical Director, or his/her designee, according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a ***Medical Condition***. Services must be medically ***and clinically*** necessary for benefits to be provided under this Agreement. The cost of services and supplies which are not Medically Necessary shall be the responsibility of the Member. ***In order to be Medically Necessary,*** services and supplies must meet the following requirements: (a) are not solely for the convenience of the patient, his/her family, or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the patient; (c) are for the diagnosis or treatment of an actual or existing ***Medical Condition*** unless being provided under GHO's schedule for preventive services; (d) are not for recreational life-enhancing relaxation or palliative therapy (except for treatment of terminal conditions); (e) are not primarily for research and data accumulation; (f) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the patient's condition or the quality of health services rendered; (g) as to inpatient care, could not have been provided in a physician's office, the outpatient department of a hospital, or a non-residential facility without affecting the patient's condition or quality of health services rendered; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits ***covered*** shall be determined by GHO's Medical Director, or his/her designee.

MEDICARE: The federal health insurance program for the aged and disabled, Title XVIII.

MEMBER: Any Subscriber or Family Dependent covered by this Agreement.

MHCN DESIGNATED FACILITY: A facility, not owned or operated by the contracting MHCN, but with which the contracting MHCN has entered into a formal legal arrangement to provide health care services to persons enrolled under this Agreement and which at such time is providing services to the Subscriber or Member that have been authorized in advance by the contracting MHCN. MHCN Designated Facilities may be changed upon appropriate notice.

MHCN DESIGNATED SELF-REFERRAL SPECIALISTS: A designated self-referral specialist is a MHCN specialist specifically identified in the Accessing Care section of this Agreement.

MHCN FACILITY: A hospital, medical center or health care center owned or operated by the contracting MHCN.

MHCN PRIMARY CARE PROVIDER: The MHCN provider ***(also referred to as "PCP" or "primary care provider")*** primarily responsible for coordinating the Member's health care under the guidelines established by the ***GHO*** Medical Director.

MHCN PROVIDER: The medical staff, clinic associate staff, and allied health professionals employed by the contracting MHCN and any other health care professional ***or provider*** with whom the MHCN has entered into a formal legal arrangement to provide health care services to persons enrolled under this Agreement, and who at such time is providing services which have been authorized in advance by the contracting MHCN, including, but not limited to, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 RCW.

OUT-OF-POCKET EXPENSES (COMMUNITY PROVIDERS): Out-of-Pocket Expenses are those expenses paid by the Subscriber or Member for Covered Services, which are applied to the Community Providers Stop Loss.

OUT-OF-POCKET EXPENSES (MHCN): Out-of-Pocket Expenses are those Copayment amounts, and other expenses paid by the Subscriber or Member for Covered Services, which are applied to the MHCN Stop Loss.

OUT-OF-POCKET LIMIT (STOP LOSS) - COMMUNITY PROVIDERS: The maximum amount of Out-of-Pocket Expenses payable during the calendar year for those Covered Services listed under Out-of-Pocket Limit in the Allowances Schedule, received by the Subscriber and his/her Family Dependents, after which the Coinsurance under this Agreement no longer applies. Expenses accrued toward the Out-of-Pocket Limit for Community Providers do not apply to the Out-of-Pocket Limit for the MHCN. The Out-of-Pocket Limit amount is set forth in the Allowances Schedule. Charges in excess of UCR, services in excess of any benefit level, and services not covered by this Agreement, are not applied to the Out-of-Pocket Limit.

OUT-OF-POCKET LIMIT (STOP LOSS) - MHCN: The maximum amount of Out-of-Pocket Expenses payable during the calendar year for those Covered Services listed under Out-of-Pocket Limit in the Allowances Schedule, received by the Subscriber and his/her Family Dependents, after which the stated out-of-pocket expenses no longer apply. Expenses accrued toward the MHCN Out-of-Pocket Limit do not apply to the Out-of-Pocket Limit for Community Providers. The Out-of-Pocket Limit amount is set forth in the Allowances Schedule. Services in excess of any benefit level, and services not covered by this Agreement, are not applied to the Out-of-Pocket Limit.

PRE-EXISTING CONDITION: A condition for which there has been a diagnosis, treatment (including prescribed drugs), or medical advice within the three (3) month period prior to the effective date of coverage. The Pre-Existing Condition wait period will begin on the first day of coverage, or the first day of the ***enrollment*** waiting period if earlier.

PREFERRED COMMUNITY PROVIDER: A Community Provider that has agreed to accept from Group Health Options, Inc. a contracted rate for services under Section XII. Services received from a Preferred Community Provider are subject to a discounted rate, less any coinsurance or deductibles as ser forth in the Allowances Schedule.

PREFERRED COMMUNITY PROVIDER CONTRACTED RATE: The discounted rate that the Preferred Community Provider has agreed to accept from Group Health Options, Inc. for medical services received by Options Members.

REFERRAL: A written temporary referral agreement ***requested*** in advance by a MHCN Primary Care Provider and approved by the MHCN, which entitles a Member to receive Covered Services from a designated health care provider at the MHCN (managed care) level of benefits. Entitlement to such Services shall not exceed the limits of the Referral, and is subject to all terms and conditions of the Referral and this Agreement. Members who have a complex or serious medical or psychiatric conditon may receive a standing Referral for specialist services. Any Referral to a specialist that requires or results in an additional Referral to another specialist or provider, must be approved by the Member's Primary Care Provider and the MHCN in order to be covered at the MHCN level of benefits.

SELF-REFERRED: Covered Services received by a Member from a Community Provider, ***designated women's health care specialist, or MHCN Designated Self-Referral Specialist*** that are not referred by the MHCN Primary Care Provider.

SERVICE AREA: Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and parts of counties as designated by ***GHO.***

SKILLED HOME HEALTH CARE: Reasonable and necessary care for the treatment of an illness or injury which requires the skill of a registered nurse or therapist, based on the complexity of the service and the condition of the patient, and which is performed directly by an appropriately licensed professional provider.

STOP LOSS (COMMUNITY PROVIDERS): ***See Out-of-Pocket Limit.***

STOP LOSS (MHCN): ***See Out-of-Pocket Limit.***

SUBSCRIBER: A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled hereunder, and for whom the premium specified in the Premium Schedule has been paid.

URGENT CONDITION: The sudden, unexpected onset of a medical condition that is of sufficient severity to require medical treatment within twenty-four (24) hours of its onset.

USUAL, CUSTOMARY, AND REASONABLE (UCR): The maximum amount payable by GHO when expenses are incurred from a Community Provider, subject to Coinsurance and Deductibles. Expenses are considered Usual, Customary, and Reasonable if (1) the charges are consistent with those normally charged by the provider or organization for the same services or supplies; and (2) the charges are within the general range of charges made by other providers in the same geographic area for the same services or supplies. Amounts charged by a Community Provider in excess of UCR rates are the responsibility of the Subscriber and/or Member.

Section II. Premiums and Fees

A. FEES. The Subscriber shall be liable for the following, as set forth in this section, when services are received by the Subscriber and any of his/her Family Dependents.

Payment of an amount billed ***by GHO*** must be received within thirty (30) days of the billing date.

1. **Copayments.** Copayments apply to some Covered Services under the MHCN (managed care) option as set forth in the Allowances Schedule. Payment of such Copayments shall be required at the time service is received from the MHCN. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service.

2. **Annual Deductible.** All Covered Services received from a Community Provider on a Self-referred basis are subject to the annual Deductible, except as set forth in the Allowances Schedule under Emergency Care and Ambulance Services.

a. The total charges for Covered Services under the Community Provider option shall be borne by the Subscriber during each calendar year until the annual Deductible shown in the Allowances Schedule is met.

b. There is an individual annual Deductible amount for each Member, and a maximum aggregate annual Deductible for each Family Unit. Once the aggregate annual Deductible amount is reached for a Family Unit in a calendar year, the individual annual Deductibles are also deemed reached for each Member during the same calendar year.

3. **Individual Annual Deductible Carryover.** Expenses applied toward the individual annual Deductible and incurred for Covered Services received by a Member under the Community Provider option during the months of October, November, and December are also applied in an equal amount toward the Member's annual Deductible for the next calendar year. The aggregate Family Unit Deductible does not carry over into the next calendar year.

4. **Coinsurance.** After the annual Deductible is satisfied, services covered under the Community Provider option are payable at the plan Coinsurance percentage as set forth in the Allowances Schedule.

   A benefit-specific Coinsurance as set forth in the Allowances Schedule applies to some Covered Services.

   Services subject to the benefit-specific Coinsurance are not subject to the plan Coinsurance.

5. **Stop Loss.**

   a. MHCN. The total Out-of-Pocket Expenses paid in any one calendar year for certain Covered Services received from or referred by a MHCN Provider shall be limited to the Stop Loss amount as set forth in the Allowances Schedule.

   b. Community Provider. The total Out-of-Pocket Expenses paid in any one calendar year for certain Covered Services received from a Community Provider shall be limited to the Stop Loss amount as set forth in the Allowances Schedule.

6. **Non-Covered Services.** Payment for non-Covered Services received from the MHCN must be received within thirty (30) days of the billing date.

B. SUBSCRIBER'S LIABILITY. The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premium, if any; (2) payment of Copayments, the annual Deductible and the Coinsurance amounts for Covered Services provided to the Subscriber and his/her Family Dependents, as set forth in the Allowances Schedule; and (3) payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Family Dependents, at the time of service.

C. SELF-PAYMENTS DURING A STRIKE, LOCK-OUT, OR OTHER LABOR DISPUTE. In the event of suspension or termination of employee compensation due to a strike, lock-out, or other labor dispute, a Subscriber may continue uninterrupted coverage under this Agreement through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out, or other labor dispute, or for six (6) months after the cessation of work.

If the Group Agreement is no longer available, the Subscriber shall have the opportunity to apply for the individual GHO Group Conversion Plan or, if applicable, continuation coverage (see Section IV.).

THE GROUP IS RESPONSIBLE FOR IMMEDIATELY NOTIFYING EACH AFFECTED SUBSCRIBER OF HIS/HER RIGHTS OF SELF-PAYMENT UNDER THIS PROVISION.

Section III. Termination

A. TERMINATION OF SPECIFIC MEMBERS. This Agreement may be terminated as to a specific Member for any of the following reasons:

1. **Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in the Enrollment and Eligibility Requirements and is not enrolled for continuation coverage as described in Section IV.A., coverage under this Agreement will terminate at the end of the month during which loss of eligibility occurs, unless otherwise stated in the Enrollment/Eligibility Requirements.

2. **For Cause.** Coverage of a Member may be terminated upon written notice for:

a. Material misrepresentation, fraud, or omission of information in order to obtain coverage for the Member or others. This includes failure to answer fully and correctly all questions contained in the application forms. In such event, GHO may, within two (2) years from the date of the application, refuse to cover any service for a condition(s) to which such question was relevant, or may nonrenew or cancel the Member's coverage upon five (5) working days written notice.

b. Permitting the use of a GHO identification card or number by another person, or using another person's identification card or number to obtain care to which one is not entitled.

3. Nonpayment of premium or contribution for a specific Member by the Group.

4. In no event will a Member be terminated solely on the basis of their physical or mental condition provided they meet all other eligibility requirements set forth in this Agreement.

5. The Member may appeal the termination decision through GHO's grievance process as set forth in Section VIII.

B. PERSONS HOSPITALIZED ON THE DATE OF TERMINATION. A Member who is receiving Covered Services as a registered bed patient in a hospital on the date of termination shall continue to be eligible for Covered Services ***while an inpatient*** for the condition for which the Member was hospitalized, until ***the first of the following events occur:***

- ***The Member no longer meets medical criteria to be an inpatient at the facility;***
- ***The remaining benefits available under this Agreement for the confinement are exhausted, regardless of whether a new calendar year begins;***
- ***The Member becomes covered under another Agreement with the group health plan that provides benefits for the confinement;***
- ***The Member becomes enrolled under an Agreement with another carrier that would provide benefits for this confinement if this Agreement did not exist;***
- ***Medicare eligibility.***

This provision will not apply if the Member is covered under an Agreement that provides benefits for the confinement at the time coverage would terminate except as set forth in this section, or if the Member is eligible for COBRA continuation coverage as set forth in Section IV.

C. SERVICES PROVIDED AFTER TERMINATION. The Subscriber shall be liable for payment of all charges for services and items provided to the Subscriber and all Family Dependents by MHCN Providers, MHCN Designated Facilities, non-MHCN Facilities, or Community Providers after the effective date of termination, except those services covered under Section III.B. Any services provided by the MHCN shall be charged according to the Fee Schedule. Services provided. Services provided by non-MHCN Providers will be charged on the provider's fee for service basis.

Unless the Group has chosen to accept this resposibility, a certificate of creditable coverage ***(which provides information regarding the Member's length of coverage under this Agreement)*** will be issued automatically upon termination of coverage, and may also be obtained upon request.

Section IV. Continuation Coverage, Conversion, and Transfer

A. CONTINUATION COVERAGE UNDER FEDERAL LAW

This subsection A. only applies to employer groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, and only applies to grant continuation of coverage rights to the extent required by federal law. Upon loss of eligibility, continuation of Group coverage may be available to a Member for a limited time after the Member would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 and amendments thereto (collectively "COBRA"). The Group shall inform Members of ***the*** COBRA election process and how much the Member will be required to pay directly to the Group.

B. GHO GROUP CONVERSION PLAN.

1. Eligibility. Any Subscriber or Family Dependent ***not entitled to Medicare may*** convert to one of GHO's Group Conversion Plans if his/her coverage under this Agreement is terminated for any reason other than cause (See Section III.B.2.). Following termination of marriage or death of the Subscriber, all Family Dependents (including those who are not eligible for Medicare coverage) are entitled to make such a conversion.

2. **Application.** Application for conversion must be made within thirty-one (31) days following termination under this Agreement. Enrollment under the GHO Group Conversion Plan is subject to all terms and conditions of such plan including premium payment. A physical examination or statement of health is not required for enrollment in the Group Conversion Plan. The Pre-existing Condition limitation under the Group Conversion Plan will apply only to the extent that the limitation remains unfulfilled under this Agreement.

By exercising Group Conversion rights, the Member may waive guaranteed issue and Pre-existing conditions waiver rights under Federal regulations.

C. ***CONTINUATION OPTION. A Member no longer eligible for coverage under this Agreement (except in the event of termination for cause) may continue coverage for a period of up to three (3) months subject to notification to and self-payment of premium to the Group. This provision will not apply if the Member is eligible for the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).***

Section V. Coordination of Benefits

As described below, benefits provided under the Group Medical Coverage Agreement ***are subject to this provision.***

Benefits shall not be coordinated between the two (2) health care delivery options under the Group Medical Coverage Agreement; i.e., the MHCN option and the Self-referred Community-based Provider.

"Allowable expense" means any necessary, reasonable and customary items of expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered an allowable expense.

The Coordination of Benefits Standards describe the method of deciding which medical plan will determine its benefits first (the primary plan), and which medical plan will be the secondary plan. The secondary plan pays eligible charges after the primary plan has determined its full benefit payment. The Subscriber is an eligible employee of a company who is enrolled under a medical plan offered by the employer, and is entitled to receive benefits and services provided by the plan.

When two (2) health care plans are in effect and one of the plans does not have a coordination of benefits provision and is a self-insured plan, it may elect to be always excess, in which case the plan that includes a coordination of benefits provision is always primary. If both plans have a coordination of benefits provision, the plan covering the patient as an employee will be primary. The plan covering the patient as the spouse of an employee will be secondary.

Where a dependent is covered under more than one Subscriber's plan, the benefits of a plan which covers a dependent of an employee whose date of birth occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of an employee whose date of birth occurs later in a calendar year, except for a dependent child whose parents are separated or divorced. This birth date refers only to the month and day, not the year, in which a person was born.

If parents of a dependent child are separated or divorced, the plan covering the parent with custody is primary unless a court decree establishes that the parent without custody is financially responsible for the health care expenses of the child, in which case such parent's plan is primary. If the parent with custody has remarried, the benefits of the plan that covers the child as a dependent of the parent with custody shall be determined before the benefits of the plan that covers that child as a dependent of the stepparent. The benefits of a plan that covers the child as a dependent of the stepparent will be determined before the benefits of the plan that covers the child as a dependent of the parent without custody.

If none of the above rules determine the order of benefits, then the plan that has covered the Member for the longer period of time shall be determined before the benefits of a plan that has covered such person the shorter period of time, provided that if one of the two plans is a laid off or retired employee plan, the plan of the person that is actively employed will be primary and the plan of the laid off or retired employee will be secondary. If either plan does not have a provision regarding laid off or retired employees, then the above provision shall not apply.

If the above rules still do not determine the order of benefits, the benefits of the plan that covered an employee or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

In order to ensure appropriate coordination of benefits and timely payment, the Member must submit all charges for services received from non-GHO plans to both GHO and the other medical plan at the same time. The Member is responsible for notifying GHO to submit charges for covered services received under a non-GHO medical plan.

This provision does not apply to any individual insurance policy or contract. Refer to the Group Medical Coverage Agreement for a complete explanation.

Effect of Medicare. ***For GHO Members eligible for Medicare, Medicare secondary payor guidelines and regulations will determine who is primary.***

- When the Managed Health Care Network (MHCN) renders care to a GHO Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payor under Medicare secondary payor guidelines and regulations, GHO will seek Medicare reimbursement for all Medicare covered services.

- When a GHO Member, who is a Medicare beneficiary and for whom Medicare has been deemed to be the primary bill payor under Medicare secondary payor guidelines and regulations, seeks care on a Self-referred basis from Community-based Providers, GHO has no obligation to provide any benefits except as specifically outlined in the Community Provider option under Section XII.A. When Meidcare is the prinary bill payor, all Medicare Part A deductibles and coinsurances are covered by the plan. Medicare Part B services, deductibles and coinsurances on self-referred, non-Emergency care from Community Providers are not covered by the plan.

Section VI. Subrogation *and Reimbursement Rights*

"Injured person" under this section means a Member covered by this Agreement who sustains compensable injury ***and any spouse, dependent, or other person or entity that may recover on behalf of such Member including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member.*** "GHO's medical expenses" means the expenses incurred and the reasonable value of the benefits provided by GHO for the care or treatment of the injury sustained.

If the injured person's ***injuries were caused*** by a third party giving rise to a claim of legal liability against the third party, GHO shall have the right to recover GHO's medical expenses ***from any source available to the injured person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorists coverage.*** This right is commonly referred to as "subrogation." GHO shall be subrogated to and may enforce all rights of the injured person to the extent of GHO's medical expenses.

If the injured person who receives GHO medical expenses is entitled to receive money from any source as a result of the events causing the injury, including but not limited to any party's liability insurance or uninsured/underinsured motorists proceeds, then GHO's medical expenses provided or to be provided to the injured person or secondary, not primary, and will be paid only if the injured person fully cooperates with the terms and conditions of this Agreement. As a condition of receiving benefits under this Agreement, the injured person agrees that acceptance of GHO services is constructive notice of this provision in it's entirety and agrees to reimburse GHO for the benefits the injured received as a result of the events causing the injury. GHO's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the injured person for the loss sustained, including general damages. Full compensation shall be measured in an objective case by case basis unless the injured person settles with the at fault party prior to trial for less than available policy limits in which case full compensation shall be the amount of the settlement.

The injured person and his or her agents must cooperate fully with GHO in its efforts to collect GHO's medical expenses. This cooperation shall include supplying GHO with information about any defendants and/or insurers related to the injured person's claim. The injured person and his or her agents shall permit GHO, at GHO's option, to associate with the injured party or to intervene in any action filed. ***If the injured person takes no action to recover money from any source, then the injured person agrees to allow GHO to initiate its own direct action for reimbursement or subrogation.***

The injured person and his or her agents shall do nothing to prejudice GHO's subrogation and reinmbursement rights. The injured person shall promptly notify GHO of a tentaive settlement and shall not settle a claim without protecting GHO's interest. If the Member fails to cooperate fully with GHO in recovery of medical expenses as described above, the Member shall be responsible for reimbursing GHO for such medical expenses.

To the extent that the injured person recovers from any available source, the injured person agrees to hold such is monies in trust or in their possession until GHO's subrogation and reimbursement rights are fully determined.

GHO shall not pay any attorneys' fees or collection costs to attorneys representing the injured person unless there is a written fee agreement signed by GHO prior to any collection efforts. When reasonable collection costs have been incurred with GHO's prior written agreement to recover GHO's medical expenses, there shall be an equitable apportionment of such collection costs between GHO and the injured person subject to a maximum responsibility of GHO equal to one-third of the amount recovered on behalf of

GHO. ***Under no circumstances will GHO pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHO.***

If it becomes necessary for GHO to enforce the provision of this section by initiating any action against the injured person or his or her agent, then the injured person agrees to pay GHO's attarney's fees and costs associated with the action.

Implementation of this section shall be deemed a part of claims administration under this Agreement and GHO shall therefore have sole discretion to interpret its terms.

This provision does not apply to occupationally incurred disease, sickness and/or injury (see Section XIII.).

Section VII. Utilization Management

All benefits under this Agreement are limited to Covered Services that are Medically Necessary as defined in Section I. and set forth in Section XII. GHO may review a Member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, GHO may deny coverage if, in its determination, such services are not Medically Necessary and ***in the case of out of network services,*** Usual, Customary and Reasonable as set forth above. Such determination shall be based on established clinical criteria.

GHO will not deny coverage retroactively for services it has previously authorized and which have already been provided to the Member.

Section VIII. Grievance Procedures *for Complaints and Appeals*

A grievance is a complaint or appeal as set forth below.

Filing a Complaint or Appeal

The complaint process is available for a Member to express dissatisfaction about customer service or the quality or availability of a health service.

The appeal process is available for a Member to seek reconsideration of a denial of benefits.

Complaint Handling

Step 1: The Member should contact the person involved, explain his or her concerns and what he or she would like to have done to resolve the problem. The Member should be specific and make his or her position clear.

Step 2: If the Member is not satisfied, or if he or she prefers not to talk with the person involved, the Member should call the department head or the manager of the medical center or department where he or she is having a problem. That person will investigate the Member's concerns. Most concerns can be resolved in this way. However, if the Member is still dissatisfied, they should call the Customer Service Center.

Step 3: Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his or her concerns and to state what he or she thinks would be a fair resolution to the problem. A customer service representative or service quality coordinator will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This type of complaint can take up to 30 days to resolve after receipt of your written statement.

If the Member is dissatisfied with the resolution of the complaint, he or she may contact the service quality coordinator or the Customer Service Center to appeal. A decision regarding the appeal will be made within 30 days and written notice of the decision will be provided to the Member.

Appeals Process

Step 1: If the Member wishes to appeal a decision, he or she must submit a request for appeal ***either orally or in writing*** within 180 days of the denial notice he or she received. The Member must specify why he or she disagrees with the decision. GHO will notify the Member of its determination or request the Member's written permission for an extension of time within 30 days of receipt of the request for appeal.

If the Member is located west of the Cascade mountains, to GHO, PO Box 34588, Seattle WA 98124-1588, (206) 901-4844 (toll free 1-888-901-4636); or if the Member is located east of the Cascade mountains, to GHO, P.O. Box 204, Spokane, WA 99224-0204, (509) 838-9100 (toll free 1-800-497-2210).

If the appeal request is for an experimental or investigational exclusion or limitation, GHO will make a determination and notify the Member in writing within 20 working days of receipt of a fully documented request. In the event that additional time is required to make a determination, GHO will notify the Member in writing that an extension in the review timeframe is necessary. Under no circumstances will the review timeframe exceed 20 days without the Member's written permission.

There is an expedited appeals process in place for cases which meet criteria or where the Member's doctor states clinical urgency exists. If a delay would jeopardize the Member's life, or materially jeopardize the Member's health, the Member can request an expedited appeal in writing to the above address, or by calling GHO in western Washington at (206) 901-4844 (toll free 1-888-901-4636), or in eastern Washington at (509) 838-9100, (toll free 1-800-497-2210), and ask to be connected with the Appeals Department. The Member's request for an expedited appeal will be processed and a decision issued no later than seventy-two hours after receipt.

If GHO fails to grant or reject the Member's request within the applicable required timeframe, the Member may proceed as if the appeal had been rejected.

Step 2: If the Member is not satisfied with the decision reached by the appeals coordinator regarding a denial of benefits, he or she may request a hearing by the appeals committee by submitting the appeal within 30 days of the date of the decision letter: if the Member is located west of the Cascade mountains, to GHO, PO Box 34588, Seattle WA 98124-1588, or if the Member is located east of the Cascade mountains to GHO, PO Box 204, Spokane, WA 99224-0204.*

The appeals committee is the final review authority within GHO. Its decisions are final. Members are encouraged to present their case to the appeals committee in person. ***The hearing and written notification to the Member of the appeals committee decision, will be made within thirty working days of the Member's request.***

Step 3: If the Member is not satisfied with the committee's decision, or if GHO exceeds the timeframes stated ***in Step 1 and 2*** above without good cause and without reaching a decision, his or her final level of appeal is available through an independent review organization. An independent review organization is not legally affiliated or controlled by GHO.*

*If the Member's health plan is governed by ERISA (most employment related health plans, other than those sponsored by governmental entities or churches – ask your employer about your plan), the Member has the right to file a lawsuit under section 502(a) of ERISA to recover benefits due to the Member under the plan at any point after completion of step 1 of the appeals process. ***Members may have other legal rights and remedies available under state or federal law.***

Section IX. Miscellaneous Provisions

A. IDENTIFICATION CARDS. GHO will furnish cards, for identification only, to all persons enrolled under this Agreement.

B. ADMINISTRATION OF AGREEMENT. GHO may adopt reasonable policies and procedures to help in the administration of this Agreement.Group Health Options, Inc.. reserves the right to construe the provisions of this Medical Coverage Agreement, and to determine any and all questions pertaining to benefit entitlement and coverage.

C. MODIFICATION OF AGREEMENT. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Agreement, convey or void any coverage, increase or reduce any benefits under this Agreement or be used in the prosecution or defense of a claim under this Agreement.

D. CONFIDENTIALITY. ***Each party acknowledges that performance of its obligations under this Agreement may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, employee benefits information, employee addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding Group's employees (collectively the "Information"). The Information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such Information in order to perform the services to be performed by such party pursuant to this Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them, or (ii) pursuant to court order (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request that the disclosing party disclose Information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek***

an appropriate protective order. Each party shall maintain the confidentiality of medical records and confidential patient and employee Information as required by applicable law.

E. RECORDS. GHO shall keep a record of all Members. Group shall forward such information as may from time to time be required by GHO to administer this Agreement. GHO shall not be liable for the fulfillment of any obligation dependent upon such information prior to its receipt in a form satisfactory to GHO. Incorrect information furnished may be corrected if GHO shall not have acted to its prejudice by relying on it. All records which have a bearing on coverage shall be open for inspection by GHO at any reasonable time.

Section X. Claims

Claims for benefits may be made before or after services are obtained. To make a claim for benefits under this agreement, a Member (or the Member's authorized representative) must contact GHO Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If a Member ***receives a bill*** for Covered Services, ***the Member must,*** within sixty (60) days of the service date, or as soon thereafter as is reasonably possible, ***either a) contact GHO Customer Service to make a claim, or b) pay the bill and submit a claim for reimbursement of Covered Services to GHO.*** In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the service date.

GHO will generally process claims for benefits within the following timeframes after GHO receives the claims:

- ***Pre-service claims-within 15 days, or an extension of up to 15 days will be requested***
- ***Claims involving urgently needed care – within 72 hours***
- ***Concurrent care claims-within 24 hours***
- ***Post service claims-within 30 days, or an extension of up to 15 days will be requested.***

In some circumstances, timeframes may be extended if GHO requests additional information.

Section XI. Enrollment Schedule

A. ENROLLMENT

1. Application for Enrollment. Application for enrollment shall be made on an application form furnished and approved by GHO. No person shall be enrolled or dues accepted until this completed application has been received and approved by GHO. The Group is responsible for submitting completed application forms to GHO.

a. **Special Enrollment Periods.**

i. Loss of Coverage. GHO will allow special enrollment periods for persons who initially declined enrollment when newly eligible because such persons had another health care plan available through Group or other insurance coverage and have had such other coverage terminated due to cessation of employer contributions, exhaustion of COBRA continuation coverage, or loss of eligibility except for loss of eligibility or cause (GHO or Group may require that when initially offered coverage such persons submitted a written statement declining because of other coverage) Application must be made within thirty-one (31) days of the termination of previous coverage or acquisition of a new dependent.

ii. New Dependents. In the event a Subscriber or person eligible to be a Subscriber acquires a person eligible to be a Family Dependent by birth, marriage, adoption or placement for adoption, GHO will allow special enrollment periods for the person eligible to be a Subscriber, his or her spouse and the newly-acquired Family Dependent. Application must be made within thirty-one (31) days of acquisition of the Family Dependent, except that sixty (60) days is permitted to enroll newborn and adopted children as described below.

b. **Newly Eligible Persons.** Newly eligible Subscribers may make written application for enrollment to the Group within thirty-one (31) days of eligibility. If the Subscriber wishes to enroll his/her eligible Dependents, application must be made during this same thirty-one (31) day period.

Written application for enrollment for a newly dependent person, other than a newborn or adopted newborn child, must be made to the Group within thirty-one (31) days after the dependency occurs.
In the event there is a change in the monthly premium payment as a result of the addition of a newborn child, the Subscriber must make written application for enrollment to the Group within sixty (60) days following the date of birth; however, it is advised that the Subscriber notify GHO in the event of the addition of a newborn to avoid delays in payment of claims.

In the event there is a change in the monthly premium payment as a result of the addition of an adoptive child, including adopted newborns, the Subscriber must make written application within sixty (60) days from the day that the child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes financial responsibility for the medical expenses of the child; however, it is advised that the Subscriber notify GHO in the event of the addition of an adopted child, including adopted newborns, to avoid delays in payment of claims.

When there is no change in the monthly premium payment, it is strongly advised that you enroll your newborn or newly adoptive child, including adopted newborns, as a dependent with your employer to avoid delays in payment of claims.

c. **Annual Enrollment Period.** A person not enrolled as a Subscriber or Family Dependent when newly eligible, as described above, may make written application during the Group's Annual Enrollment period.

2. **Limitation on Enrollment.** The Group Medical Coverage Agreement will be open for application as set forth in Section XI.A.1. ***Subject to prior approval by the Office of the Insurance Commissioner,*** GHO may limit enrollment, establish quotas, or set priorities for acceptance of new applications.

B. PERSONS ENTITLED TO, OR ELIGIBLE TO PURCHASE MEDICARE.

1. Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), actively employed Subscribers and their spouses who are ***eligible for*** Medicare benefits must decide whether to choose the benefits of this Agreement or the Medicare program as the primary source of health care coverage. The Group is responsible for providing the Subscriber with necessary information regarding TEFRA eligibility and the selection process.

   Subscribers and covered dependents who are eligible for Medicare (as set forth below) must, effective the date that Medicare would become the primary payor, enroll in Medicare Parts A ***and*** B. For purposes of this section, an individual shall be deemed eligible for Medicare when he or she has the option to receive Part A Medicare benefits, irrespective of whether the individual elects to enroll in Part B coverage under the federal regulations. Failure to do so upon the effective date of Medicare eligibility will result in termination of coverage under this group Agreement.

2. Except as otherwise required by TEFRA, GHO will only provide benefits for Covered Services, subject to the Coordination of Benefits provision under this Agreement as set forth in Section V.

C. PERSONS WHO ARE NOT ENTITLED TO, OR ELIGIBLE TO PURCHASE MEDICARE. If a Member otherwise qualifies for Medicare but is not eligible to purchase Medicare, the Member may continue coverage under this Agreement upon payment of the applicable premium as set forth in the Premium Schedule.

Section XII. Schedule of Benefits

This Section XII. describes all services that will be covered under this Agreement. Coverage received under the managed care option (MHCN*)* is limited to those services determined by the ***GHO*** Medical Director, or his/her designee, to be Medically Necessary for the treatment of a Medical Condition.

To be covered under the managed care option, all services must be provided by MHCN Providers at MHCN Facilities, or must be Referred by the MHCN Primary Care Provider.

Coverage received from a Community Provider is limited to those services determined by GHO to be Medically Necessary by GHO's Medical Director for the treatment of a Medical Condition of the Member. Members generally do not need to obtain Referrals prior to obtaining services covered under this Agreement; however, most hospitalizations are subject to a preauthorization requirement. GHO reserves the right to pay benefits directly to the provider, and/or Member. Coverage is limited to the Preferred Community Provider Contracted Rate or Usual, Customary and Reasonable charges, less any applicable Deductible and Coinsurance amounts as shown in the Allowances Schedule.

Coverage under this Section XII. is subject to all terms and conditions of this Agreement, including, ***without limitation, accessing care provisions,*** Section XIII. Exclusions and Copayments, Deductibles and Allowances shown in the Allowances Schedule.

Benefits paid under one option will not be duplicated under the other option.

A. HOSPITAL CARE

Hospital ***services are*** covered, limited to the following services, when (1) services received from the managed care network are provided or Referred by the MHCN**,** or (2) Community Provider services are authorized in advance by GHO:

1. Room and board, including private room when prescribed as Medically Necessary, and general nursing services.

2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory, and radiotherapy services).

3. As a cost-effective alternative in lieu of otherwise covered, Medically Necessary hospitalization or other covered, Medically Necessary institutional care, alternative care arrangements may be covered. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined appropriate and Medically Necessary based on the patient's medical condition. Such determination of medical appropriateness and necessity, and authorization of coverage must be made in advance by GHO. ***Such care will be covered to the same extent that the replaced hospital care is covered as set forth in the Allowances Schedule.***

4. Drugs and medications ***administered during confinement.***

5. Special duty nursing (when prescribed as Medically Necessary).

6. Maternity hospitalization and delivery.

All inpatient admissions prescribed by a Community Provider must be authorized in advance by GHO. A Member receiving the nonscheduled services listed below is required to notify GHO within twenty-four (24) hours following a nonscheduled admission, or as soon thereafter as medically possible: Labor and delivery, emergency care services, and inpatient admissions needed for treatment of urgent Conditions that cannot reasonably be delayed until preauthorization can be obtained. Except as specifically provided herein, all scheduled inpatient hospital admissions must be formally preauthorized by GHO at least seventy-two (72) hours in advance of admission. If the Member does not obtain authorization prior to or following inpatient admission as described above, and GHO subsequently determines that the care, while otherwise covered, could have been provided on an outpatient basis, the Member shall be responsible for twenty percent (20%) of total hospital charges, not to exceed five hundred dollars ($500), which shall be considered non-Covered Services. All remaining charges for Covered Services are subject to the annual Deductible and Coinsurance as set forth in the Allowances Schedule.

Members may not transfer to a MHCN hospital or MHCN-designated hospital following a nonemergent, scheduled admission to a non-MHCN hospital or non-MHCN designated hospital while hospitalized in a non-MHCN hospital or non-MHCN designated hospital. Transfer to a MHCN hospital following an Emergency admission to a non-MHCN hospital is described in Section XII.L. Coverage for Emergency care in a non-MHCN Facility or non-MHCN Designated Facility is set forth in Section XII.L.

B. MEDICAL AND SURGICAL CARE

Medical and surgical services are ***covered***, limited to the following, when (1) services received from the managed care network are prescribed by the MHCN Provider**,** or (2) Community Provider services are provided by or under the direct supervision of a Community Provider, duly licensed and acting within the scope of his/her practice:

1. Surgical services.

2. Diagnostic x-ray, nuclear medicine, ultrasound, and laboratory services.

3. Family planning counseling services.

4. Hearing aid exams, hearing aids, and fittings when authorized by a physician, as set forth in the Allowances Schedule.

   The number of hearing aids will be limited to one per ear during any period of three (3) consecutive years. Hearing or audiometric examinations to determine hearing loss are covered if (1) provided at the MHCN, or upon referral by a MHCN Provider under the managed care option, or (2) provided by a Community Provider under the Community Provider option.

Excluded from coverage are the following:

a. Replacement costs of hearing aids due to loss, breakage, or theft, unless at the time of such replacement the Member is eligible under the frequency limitation of one hearing aid per ear during any period of three (3) consecutive years.
b. Replacement parts, replacement batteries, and maintenance cost.

5. Blood ***and blood*** derivatives and their administration.

6. Licensed Nurse Practitioner (ARNP) and physician visits (including consultations and second opinions) necessary for the diagnosis and treatment of illness or injury in the hospital or office.

7. Preventive care (well care) services for health maintenance.

   MHCN: Preventive services for health maintenance limited to routine mammography screening; routine physical examinations and routine laboratory tests for cancer screening in accordance with GHO's established well-care protocol for detection of disease; and immunizations and vaccinations which are listed as covered in the ***GHO*** Drug Formulary (approved drug list). A fee may be charged by the MHCN for health education programs.

   Services provided during a preventive care visit which are not in accordance with preventive care criteria are subject to the outpatient services Copayment.

   COMMUNITY PROVIDER: Preventive care services for health maintenance limited to routine physical examinations for detection of disease and immunizations and vaccinations as set forth in GHO's "Well-Adult" and "Well-Child" care schedule are covered. ***As set forth in the Allowances Schedule.***

8. Radiation therapy services.

9. Medical and surgical services and related hospitalizations, including orthognathic (jaw) surgery for the treatment of temporomandibular joint (TMJ) disorders, are covered as set forth in the Allowances Schedule. Such disorders may exhibit themselves in the form of pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food. TMJ appliances are covered as set forth under orthopedic appliances (Section XII.H.1.).

   Orthognathic (jaw) surgery, radiology services and TMJ specialist services, including fitting\adjustment of splints, is subject to the benefit limit set forth in the Allowances Schedule.

   The following services, including related hospitalizations, are excluded regardless of origin or cause:

   - orthognathic (jaw) surgery in the absence of a TMJ diagnosis,
   - treatment for cosmetic purposes, and
   - all dental services (except as noted above), including orthodontic therapy.

   MHCN: Services received under the managed care option must be referred in advance by a MHCN Provider.

   COMMUNITY PROVIDER: Services received from a Community Provider must be authorized in advance by GHO.

10. The following services are covered (1) by the MHCN when performed by a MHCN Provider or MHCN oral surgeon under the managed care option, or (2) when performed by a licensed physician or oral surgeon under the Community Provider option: reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.

11. Medically Necessary implants, which are not experimental or investigational, are covered as determined by ***GHO's*** Medical Director, or his/her designee. Excluded are internally implanted insulin pumps, artificial hearts, artificial larynx, and any other implantable device that has not been approved by ***GHO's*** Medical Director, or his/her designee.

12. Respiratory therapy.

13. Services of a podiatrist, except routine foot care. Services received under the managed care option are available upon referral by the MHCN.

14. Dietary formula for the treatment of phenylketonuria (PKU) is covered and is not subject to a Pre-existing Condition waiting period, if any.

    Outpatient total parenteral nutritional therapy, in accordance with medical criteria as established by GHO is covered as set forth in the Allowances Schedule. Supplies and equipment necessary for its administration are covered under Devices, Equipment and Supplies.

    Outpatient enteral therapy for malabsorption and access problems is covered as set forth in the Allowances Schedule. Equipment and supplies for the administration of enteral therapy is covered under Devices, Equipment and Supplies.

    Dietary formulas, oral nutritional supplements, special diets and prepared foods/meals, except treatment of phenylketonuria (PKU) and total parenteral and enteral nutritional therapy as set forth above, are excluded.

15. Eye Examinations, Refractions and Corrective Lenses

    MHCN

    EYE EXAMINATIONS, ROUTINE:

    Routine eye examinations and refractions are covered as outlined in the Allowances Schedule. Services for routine eye examinations must be received from an MHCN provider and in accordance with the MHCN's medical criteria in order to be covered.

    EYE EXAMINATIONS FOR MEDICAL CONDITION MONITORING OR EYE PATHOLOGY:

    Routine eye examinations to monitor medical conditions are covered as often as necessary upon recommendation of a MHCN provider, as outlined in the Allowances Schedule.

    Contact lenses for eye pathology, including contact lens exam and fitting, are covered. One contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery provided the Member has been continuously covered under this Agreement since such surgery.

    Replacement of lenses for eye pathology, including following cataract surgery, will be provided only once within a twelve (12) month period and only when needed due to a change in the Member's medical condition. Replacement for loss or breakage is subject to the Lenses and Frames benefit allowance.

    Evaluations and surgical procedures to correct refractions, which are not related to eye pathology, are not covered. Complications directly resulting from these procedures are not covered.

    COMMUNITY PROVIDER

    EYE EXAMINATIONS, ROUTINE:

    Routine eye examinations and refractions are covered as outlined in the Allowances Schedule.

    EYE EXAMINATIONS FOR MEDICAL CONDITION MONITORING OR EYE PATHOLOGY:

    Routine eye examinations to monitor medical conditions are covered when Medically Necessary.

    Evaluations and surgical procedures to correct refractions, which are not related to eye pathology, are not covered. Complications directly resulting from these procedures are not covered.

    One contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery provided the Member has been continuously covered under this Agreement since such surgery.

    Replacement of lenses for eye pathology, including following cataract surgery, will be provided only when needed due to change in the Member's medical condition.

LENSES AND FRAMES

Benefits, as outlined in the Allowances Schedule, may be used toward the following in any combination, over the benefit period, until the benefit maximum is exhausted:

- Eyeglass frames
- Eyeglass lenses (any type) including tinting and coating
- Corrective industrial (safety) lenses
- Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity
- Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations
- Replacement frames, for any reason, including loss or breakage
- Replacement contact lenses
- Replacement eyeglass lenses

Benefits paid under one option will not be duplicated under the other option.

16. Maternity care, including care for complications of pregnancy, prenatal and postpartum visits, services of midwives, and hospitalization and delivery services, including home births for low risk pregnancies. Birthing tubs are not covered The Member's Physician, in consultation with the mother, will determine the mother's length of inpatient stay following delivery. Pregnancy will not be considered a pre-existing condition exclusion under this Agreement. Voluntary (not medically indicated and nontherapeutic) termination of pregnancy is covered. ***Treatment for post-partum depression or psychosis is covered only under the mental health benefit.***

    Prenatal testing for the detection of congenital and heritable disorders ***in accordance with Board of Health standards for screening and diagnostic tests during pregnancy***. Genetic testing of non-Members for the detection of congenital and heritable disorders is excluded.

17. Transplants. When authorized as medically appropriate by (1) the ***GHO's*** Medical Director, or his/her designee, and in accordance with criteria established by the MHCN, when services are received from the managed care network, or (2) GHO, in accordance with criteria established by GHO, when services are received from Community Providers**,** heart, heart-lung, single lung, double lung, kidney, simultaneous pancreas/kidney, cornea, bone marrow, and liver transplants**.** High dose chemotherapy and stem cell (obtained from the allogeneic or autologous peripheral blood or marrow as medically appropriate) support is covered when authorized as medically appropriate by GHO's Medical Director, or his/her designee. Transplant services are limited to the following:

    a. evaluation testing to determine recipient candidacy;

    b. matching tests;

    c. transplantation procedures as follows for inpatient and outpatient medical expenses. Covered procedures must be directly associated with, and occur at the time of, the transplant. Transplantation procedures are subject to the organ recipient's lifetime maximum as set forth in the Allowances Schedule.

        - hospital charges;
        - procurement center fees;
        - travel costs for a surgical team;
        - excision fees;
        - donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. GHO shalll exclude coverage for donor costs to the extent that the donor costs are reimbursable by the organ donor's insurance.

    d. follow-up services for specialty visits,

    e. rehospitalization, and

    f. maintenance medications.

Exclusions

Transportation expenses, except as set forth under Section XII.M. of this Agreement, and living expenses.

18. Treatment of growth disorders by growth hormones**,** in accordance with established criteria.

    Growth hormone treatment shall be excluded until such time as the Member has been continuously enrolled under this Agreement for twelve (12) consecutive months without any lapse in coverage.

19. Manipulative therapy of the spine as set forth in the Allowances Schedule.

    The medical necessity for manipulative therapy must meet GHO ***clinical criteria as Medically Necessary***. In order to be covered under the managed care option, manipulations must be provided by a MHCN Provider and are limited to one evaluation and ten (10) spinal manipulations only***;*** additional visits ***are covered as set forth in the Allowances Schedule when approved by GHO***. Excluded are services ***that do not meet*** GHO ***clinical criteria as Medically Necessary***, including, but not limited to, supportive care rendered primarily to maintain the level of correction already achieved, care rendered primarily for the convenience of the Member, care rendered on a non-acute, asymptomatic basis**,** or charges for office visits other than the initial evaluation.

20. Nontherapeutic sterilization procedures.

21. Diabetic training and education. The cost of educational materials is excluded.

22. Detoxification services for alcoholism and drug abuse.

    Coverage for acute chemical withdrawal is provided without prior authorization. If a Member is hospitalized for acute chemical withdrawal in a non-MHCN Facility***/program*** or non-MHCN Designated Facility***/program***, coverage is subject to all the provisions set forth in Section XII.L. including payment of the Emergency care Deductible shown in the Allowances Schedule, and notification of the MHCN by the Member, or person assuming responsibility for the Member, by way of the MHCN Notification Line within twenty-four (24) hours following admission or as soon thereafter as medically possible. Furthermore, if a Member is hospitalized in a non-MHCN Facility***/program*** or non-MHCN Designated Facility/***program***, the MHCN reserves the right to require transfer of the Member to a MHCN Facility/***program*** upon consultation between a MHCN Provider and the attending physician. If the Member refuses transfer to a MHCN Facility/***program*** or MHCN Designated Facility/***program***, all services received will be covered under the Community Provider option.

    For the purpose of this section, "acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a person for whom consequences of abstinence are so severe as to require medical/nursing assistance in a hospital setting, and which is needed immediately to prevent serious impairment to the Member's health.

23. Circumcision.

24. Bariatric surgery and related hospitalizations when GHO criteria are met. All other services required (e.g., prescribing and monitoring of drugs, structured weight loss and/or exercise programs, specialized nutritional counseling) are excluded.

    MHCN: Covered.

    Community Provider: Not covered.

25. General anesthesia services and related facility charges for dental procedures will be covered for Members under seven (7) years of age, physically or developmentally disabled persons, or for Members with a medical condition whose health would be put at risk if the dental procedure were performed in a dentist's office. Such services must be preauthorized and determined Medically Necessary by GHO. Under the managed care option, such services must be performed at a MHCN or MHCN Designated hospital or ambulatory surgery facility.

    Dentist's or oral surgeon's fees are not covered.

26. Covered Services provided by licensed acupuncturists and licensed naturopaths within their scope of licensure as set forth in the Allowances Schedule.

In order to be covered under the managed care option, services must be provided by a MHCN Provider; additional visits are covered as set forth in the Allowances Schedule when approved by GHO.

Preventive care visits to acupuncturists and naturopaths are not covered. Herbal supplements are not covered. Laboratory services are covered only when provided at a Group Health Options operated or contracted laboratory.

27. Pre-existing Conditions are covered in the same manner as any other illness.

C. CHEMICAL DEPENDENCY TREATMENT

Subject to all terms and conditions of this Agreement, care is provided as set forth below at (1) a MHCN Facility, MHCN Designated Facility, or MHCN-approved treatment ***program***, under the managed care option, or (2) an approved treatment facility under the Community Provider option, subject to the Benefit Period Allowance as described below and as shown in the Allowances Schedule.

1. Chemical Dependency Treatment Services.

For chemical dependency treatment services, Medical Necessity is defined as those services necessary to treat a chemical dependency condition that is having a clinically significant impact on an individual's emotional, social, medical, and/or occupational functioning. Under the managed care option, the ***GHO*** Medical Director or his/her designee shall make the final determination of the length and type of program and frequency of visits.

a. All alcoholism and/or drug abuse treatment services must be deemed Medically Necessary, provided at a facility as described above, and must be authorized in advance by GHO, except for acute chemical withdrawal as described in Section XII.B. Chemical Dependency treatment may include the following services received on an inpatient or outpatient basis: diagnostic evaluation and education, organized individual and group counseling, and prescription drugs and medicines (unless excluded under this Agreement).
b. Court-ordered treatment shall be provided only if determined to be Medically Necessary by GHO.

2. Benefit Period and Benefit Period Allowance.

a. Benefit Period. For the purpose of this section, "Benefit Period" shall mean a twenty-four (24) consecutive calendar month period during which the Member is eligible to receive covered Chemical Dependency treatment services as set forth in this section. The first Benefit Period shall begin on the first day the Member receives covered Chemical Dependency services and shall continue for twenty-four (24) consecutive calendar months, provided that coverage under this Agreement remains in force. All subsequent Benefit Periods thereafter will begin on the first day Covered Services are received after expiration of the previous twenty-four (24) month Benefit Period.

b. Benefit Period Allowance. The maximum Allowance available for any Benefit Period shall be the total of all Chemical Dependency benefits provided and payments made for Chemical Dependency treatment, not to exceed the Benefit Period Allowance shown in the Allowances Schedule during the Member's Benefit Period.

Any Deductibles or Copayments which may be borne by the Member under the terms of this Agreement shall not be applied toward the Benefit Period Allowance.

D. PLASTIC AND RECONSTRUCTIVE SERVICES are covered:

1. to correct a congenital disease or congenital anomaly; or

2. to correct a Medical Condition following an injury or incidental to surgery covered by GHO which has produced a major effect on the Member's appearance when in the opinion of the MHCN Provider, such services can reasonably be expected to correct the condition.

   In the case of a congenital condition which affects appearance, an anomaly will be considered to exist if the Member's appearance resulting from such condition is not within the range of normal human variation.

3. for reconstructive surgery and associated procedures following a mastectomy regardless of when the mastectomy was performed. Internal breast prostheses required incident to the surgery shall be provided.

   A Member will be covered for all stages of reconstruction on the nondiseased breast to make it equivalent in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.

Complications of covered mastectomy services, including lymphedemas, are covered. Complications of noncovered surgical services are excluded.

E. SKILLED HOME HEALTH CARE SERVICES, as set forth in this section, shall be provided (1) under the managed care option, by the MHCN's Home Health Services or when Referred in advance by a MHCN Primary Care Provider to a MHCN-authorized home health agency, or (2) under the Community Provider option, by a State-licensed home health agency when prescribed by a physician. In order to be covered, the following criteria must be met:

1. The Member is unable to leave home due to his or her health problem or illness (unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home);

2. the Member requires intermittent Skilled Home Health Care services, as described below; and

3. a MHCN Primary Care Provider under the managed care option, or GHO under the Community Provider option, has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

Covered Services for home health care may include the following when (1) prescribed by a MHCN Primary Care Provider under the managed care option, or (2) authorized by GHO under the Community Provider option, and when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy, and medical social worker and limited home health aide services. Home health services are provided on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for Skilled Home Health Care services.

Excluded are: custodial care and maintenance care; private duty or continuous nursing care in the Member's home; housekeeping or meal services; care in any nursing home, convalescent facility or skilled nursing facility; any care provided by or for a member of the patient's family; and any other services rendered in the home which are not specifically listed as covered in Section XII.

F. HOSPICE

Hospice services as set forth in this section shall be provided (1) under the managed care option when provided by the MHCN's Hospice Program or when Referred in advance by a MHCN Primary Care Provider to a MHCN-approved hospice agency, or (2) at the Community Provider option when a physician and the hospice agency determine that the Member's illness can be appropriately managed in the home. Members who elect to receive Hospice Services do so in lieu of curative treatment for their terminal illness for the period that they are in the approved Hospice Program. To receive services under the approved Hospice Program, the Member is required to sign the hospice election form. This is done with the understanding that he/she may terminate participation in the hospice program at any time, and upon termination, begin receiving curative treatment services again.

Hospice Program

1. Eligibility. Hospice services, as set forth below, shall be provided to Members for as long as the following criteria are met:

a. A physician has determined that the Member's illness is terminal and life expectancy is six (6) months or less;
b. the Member has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Member's terminal illness);
c. the Member has elected in writing to receive hospice care through the Hospice Program;
d. the Member has available a primary care person who will be responsible for the Member's home care; and
e. a physician and the hospice agency determines that the Member's illness can be appropriately managed in the home.

2. Hospice Care shall be defined as a coordinated program of palliative and supportive care for dying persons by an interdisciplinary team of professionals and volunteers centering primarily in the Member's home.

3. Covered Services. Hospice services may include the following as prescribed by a physician and rendered pursuant to an approved hospice plan of treatment:

a. Home Services

i. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse, and homemaker services.

ii. Continuous care services in the Member's home when prescribed by a physician, as set forth in this paragraph. Continuous home care period is defined as "skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill patient at home." Continuous home care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse, or Home Health Aide under the supervision of a Registered Nurse. Continuous home care is provided up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a physician determines that the Member would otherwise require hospitalization in an acute care facility.

b. Inpatient Hospice Services for short-term care shall be provided according to the provisions set forth in Section XII.A., except that inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence in order to continue care for the Member in the temporary absence of the Member's primary care giver(s).

c. Other hospice services may include the following:

i. Drugs and biologicals that are used primarily for the relief of pain and symptom management;
ii. medical appliances and supplies primarily for the relief of pain and symptom management;
iii. counseling services for the Member and his/her primary care-giver(s); and
iv. bereavement counseling services for the family.

4. Hospice Exclusions:

a. Financial or legal counseling services.
b. Meal services.
c. Custodial or maintenance care in the home or on an inpatient basis, except as provided above.
d. Services not specifically listed as covered by this Medical Coverage Agreement.
e. Any services provided by members of the patient's family.
f. All other exclusions listed in Section XIII. Exclusions of this Medical Coverage Agreement, apply.

G. REHABILITATION SERVICES are covered as set forth in this section, limited to the following: physical therapy; occupational therapy; and speech therapy to restore function following illness, injury, or surgery. Services are subject to all terms, conditions, and limitations of this Agreement including the following:

1. All services must be (a) provided through the MHCN or a MHCN-approved rehabilitation facility and must be prescribed and provided by a MHCN-approved rehabilitation team under the managed care option, or (b) prescribed and provided by a rehabilitation team under the Community Provider option, that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.

2. The Member must be referred for rehabilitation services in advance (1) by a MHCN Primary Care Provider under the managed care option, or (2) by his/her physician under the Community Provider option.

3. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness ***or surgery***. Such services are provided only when significant, measurable improvement to the Member's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph one (1) above.

4. Coverage for inpatient and outpatient services is limited to the Allowances set forth in the Allowances Schedule.

Services excluded under this benefit include: specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy, and speech therapy services when such services are available (whether application is made or not) through governmental programs; programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning (except for neurodevelopmental therapies); recreational life-enhancing relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any treatment not considered Medically Necessary; any services not specifically included as covered in this section; and any services that are excluded under Section XIII.

Neurodevelopmental Therapies for Children Age Six (6) and Under. When determined to be Medically Necessary (1) by ***GHO's*** Medical Director, or his/her designee, under the managed care option, or (2) by GHO under the Community Provider option, physical therapy, occupational therapy, and speech therapy services for the restoration and improvement of function shall be covered for neurodevelopmentally disabled children age six (6) and under. Coverage includes maintenance of a covered Member in cases where significant deterioration in the Member's condition would result without the services.

Coverage for inpatient and outpatient services is limited to the allowances set forth in the Allowances Schedule.

Services excluded under this benefit include: specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy, and speech therapy services when such services are available (whether application is made or not) through governmental programs; programs offered by public school districts; except as set forth above, therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning; implementation of home maintenance programs; any treatment not considered Medically Necessary; any services not specifically included as covered in this Section; and any services that are excluded under Section XIII.

H. DEVICES, EQUIPMENT AND SUPPLIES listed in this section are covered as set forth in the Allowances Schedule when (1) authorized in advance by a MHCN Primary Care Provider under the managed care option, or (2) authorized in advance by GHO under the Community Provider option.

1. **Orthopedic Appliances.** When Medically Necessary, orthopedic appliances (commonly known as a brace or a splint), which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function, are covered. Medically Necessary repair, adjustment or replacement of an orthopedic appliance is covered. Covered Services are subject to the Coinsurance set forth in the Allowances Schedule. Excluded are arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; orthopedic shoes that are not attached to an appliance, and under the managed care option, any orthopedic appliances that are not listed as covered in ***GHO'***s Orthopedic Appliance Formulary.

2. **Ostomy Supplies.** Medically Necessary ostomy supplies for the removal of bodily secretions or waste through an artificial opening are covered as set forth in the Allowances Schedule.

3. **Oxygen and Oxygen Equipment.** When medical criteria as established by GHO are met, oxygen and oxygen equipment for home use is covered as set forth in the Allowances Schedule.

4. **Prosthetic Devices.** Medically Necessary prosthetic devices (which are not orthopedic appliances), commonly known as an artificial limb, etc., which are listed as covered in the GHO Prosthetic Device Formulary are covered as set forth in the Allowances Schedule.

   Medically Necessary replacement or adjustment of these devices will also be covered.

5. **Durable Medical Equipment** which is Medically Necessary, in accordance with criteria established by GHO, and listed as covered in GHO's durable medical equipment formulary, limited to the following: rental (or purchase, if the cost of purchase is less than the anticipated total rental charges as determined solely by GHO) hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps and other durable medical equipment as specifically listed in GHO's durable medical equipment formulary. Services are covered as set forth in the Allowances Schedule.

Replacement or repair of appliances, devices and supplies that are due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference are excluded.

I. TOBACCO CESSATION.

MHCN: When provided through the MHCN, services related to tobacco cessation are covered, limited to (1) participation in one individual or group program per calendar year; (2) educational materials; and (3) one course of nicotine replacement therapy per calendar year, provided the Member is actively participating in the MHCN Free and Clear Program. Covered Services are subject to the Allowances set forth in the Allowances Schedule.

COMMUNITY PROVIDER: Not covered.

J. LEGEND (PRESCRIPTION) DRUGS, MEDICINES, *SUPPLIES AND DEVICES* FOR OUTPATIENT USE as prescribed by a physician for conditions covered by this Agreement including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) insulin, diabetic supplies, including insulin syringes, lancets, urine-testing reagents, and blood-glucose monitoring reagents, and contraceptive drugs and devices and their fittings, are covered as set forth in the Allowances Schedule.

"Standard reference compendia" means the American Hospital Formulary Service -- Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia -- Drug Information, or other authoritative compendia as identified form time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

The prescription drug copayment as set forth in the Allowances Schedule applies to each 30-day supply. Copayments for single and multiple 30-day supplies of a given prescription are payable at the time of delivery. Generic drugs will be dispensed whenever available. Brand-name drugs will be dispensed if there is not a generic equivalent. In the event the Member elects to purchase brand-name drugs instead of the generic equivalent (if available), or if the Member elects to purchase a different brand-name or generic drug than that prescribed by the Member's Provider, and it is not determined to be Medically Necessary, the Member will also be subject to payment of the additional amount above the applicable pharmacy cost share set forth in the Allowances Schedule. ***Generic drugs are defined as a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are defined as a prescription drug that has been patented and is only available through one manufacturer.***

Excluded are: over-the-counter drugs, medicines, ***supplies*** and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; vitamins, including Legend (prescription) vitamins; medicines and injections for anticipated illness while traveling.

The Member will be charged for replacing lost or stolen drugs, medicines or devices.

Inside the managed care network, all drugs, supplies, medicines, and devices must be obtained at a MHCN pharmacy, ***and, unless approved by GHO in advance,*** listed in the ***GHO*** Drug Formulary unless Medically Necessary, or listed as approved MHCN stock. Outpatient drugs and medicines prescribed by a non-MHCN provider, and any other drugs, medicines and injections not listed as covered in the ***GHO*** Drug Formulary (approved drug list) are excluded. Injectables that can be self-administered are also subject to the prescription drug copayment. ***Drug Formulary (approved drug list) is defined as a list of preferred pharmaceutical products, aupplies and devices developed and maintained by Group Health Options.***

Under the Community Provider option, all drugs, supplies, medicines, and devices must be obtained at a Contracted Network Pharmacy, except for drugs dispensed by an emergency care provider or in the case that a Contracted National Network Pharmacy is not available within a 30-mile radius.

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES.

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your Agreement. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact us at 206-901-***4636*** or 1-***888-901-4636***.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of this Agreement, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

K. MENTAL HEALTH CARE SERVICES. GHO and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this ***Agreement*** and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this ***Agreement***, or if you have questions or concerns about any aspect of your mental health benefits, please contact GHO at (206) 901-4636 or 1-888-901-4636.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of the Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health provider, please call the State Health Department at 360-236-4902.

Services that are provided by a mental health practitioner, contracted or employed, to Members diagnosed as having a mental disorder that meets GHO's clinical necessity criteria for treatment, will be covered as mental health care, regardless of the cause of the disorder.

1. **Outpatient Services.** ***Outpatient*** mental health services place priority on restoring ***the Member to his/her level of functioning prior to the onset of acute symptoms or to achieve a clinically appropriate level of stability as determined by the GHO Medical Director, or his/her designee. Treatment for clinical conditions may utilize psychiatric, psychological and psychotherapy services to achieve these objectives***. Coverage for each Member is provided according to the Outpatient Mental Health Allowance set forth in the Allowances Schedule. Psychiatric medical services including medical management and ***prescriptions*** are covered as set forth in Sections XII.B. and XII.J.

   Under the managed care option, ***GHO's Medical Director, or his/her designee, shall determine*** the length and type of treatment ***plan and/or*** program and the frequency of visits. ***Services must be provided by or authorized under Referral from the MHCN Behavioral Health Services. MHCN clinics and contracted practitioner offices may have office policies that determine how missed appointments will be managed. Payment for charges of missed appointments are the responsibility of the Member.***

   Under the Community Provider option, outpatient mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57); a psychologist (licensed under RCW 18.83); a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24.); a master's level therapist (certified under RCW 18.19***), or*** advanced practice psychiatric nurse (licensed under RCW 18.79). Services provided by any provider other than those listed above are excluded.

2. **Inpatient Services.** Charges limited to the services described in this section, including psychiatric emergencies resulting in inpatient services, shall be covered up to the maximum benefit as set forth in the Allowances Schedule. Acute inpatient mental health treatment and stabilization of psychiatric emergencies must be (a) referred in advance by the MHCN mental health provider and provided in MHCN-approved hospitals under the managed care option, and (b) provided in a hospital or facilities approved specifically for treatment of mental or nervous disorders under the Community Provider option. All inpatient mental health care must be authorized in advance by the MHCN mental health provider, or his/her designee under the managed care option. When medically indicated, outpatient electro-convulsive therapy (ECT) is covered in lieu of inpatient services.

   When authorized in advance (1) the MHCN's mental health provider, or his/her designee under the managed care option, or (2) by GHO under the Community Provider option, partial hospitalization and outpatient electro-convulsive therapy ***treatments*** are covered subject to the maximum inpatient benefit limit described in the Allowances Schedule. Every two (2) partial hospitalization days or two (2) electro-convulsive therapy treatments are equivalent to one inpatient hospital day. The total maximum annual benefit under this section shall not exceed the number of inpatient days described in the Allowances Schedule.

   Subject to the maximum Inpatient Mental Health Care Allowance as set forth in the Allowances Schedule, services provided under involuntary commitment statutes shall be covered at facilities approved by GHO . Services for any ***involuntary*** court-ordered treatment program beyond the seventy-two (72) hours shall be covered only if determined to be Medically Necessary, approved (1) by ***GHO's*** Medical Director, or his/her designee, and provided by a MHCN-approved facility under the managed care option, or (2) by GHO under the Community Provider option.

   Coverage for voluntary and involuntary Emergency inpatient psychiatric services is subject to the Emergency care benefit described in Section XII.L. All other voluntary psychiatric care must be authorized in advance (1) the MHCN's mental health provider, or his/her designee under the managed care option, or (2) by GHO under the Community Provider option; the facility must be approved by GHO. All voluntary care not authorized in advance by the MHCN's mental health provider, or his/her designee, is not covered.

3. **Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services.**

   Covered Services are limited to those provided for covered ***clinical*** conditions for which, in the opinion of (1) ***GHO's*** Medical Director, or his/her designee under the managed care option, or (2) the attending mental health provider and GHO under the Community Provider option, are considered to be Medically Necessary and for which ***reduction or removal of acute clinical symptoms*** or stabilization can be expected.

   Partial hospitalization programs and electro-convulsive therapy are covered only under subsection XII.K.2. (Inpatient Services).

Also excluded are all forms of day treatment ***(non-partial hospital programs) and*** custodial care. ***Treatment specific to and solely for personality disorders, learning, communication and motor skills disorders, mental retardation, academic or career counseling, are not covered. Treatment specific to and solely for sexual and identity disorders, personal growth or relationship enhancement are not covered.*** Specialty programs for mental health therapy ***which are not specifically authorized and approved by GHO;*** court-ordered treatment which is not specifically described above; and any services not specifically included as covered in this Section. All other provisions, exclusions and limitations under this Agreement also apply. Under the Community Provider option, charges for missed visits are also excluded.

L. EMERGENCY/URGENT CARE

Emergency Care (see Section I. for a definition of Emergency):

1. **At a MHCN Facility or MHCN Designated Facility.** Emergency care for all Covered Services is covered subject to payment of the Emergency care Copayment as shown in the Allowances Schedule.

   Inpatient Emergency care received at a MHCN Designated Facility is also subject to:

   a. notification of GHO by the Member, or person assuming responsibility for the Member, by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible;
   b. transfer of care to a MHCN Provider; and
   c. transfer to another MHCN Facility or MHCN Designated Facility if transferability is medically possible as determined by the MHCN.

2. **At a non-MHCN Facility or non-MHCN Designated Facility.** Usual, Customary and Reasonable charges for covered Emergency care is covered subject to:

   a. payment of the Emergency care Deductible shown in the Allowances Schedule; and
   b. notification of GHO by the Member, or person assuming responsibility for the Member, by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.

3. **Waiver of Emergency Care Copayment/Deductible.**

   a. Waiver for Multiple Injury Accident. If two or more members of the Family Unit require Emergency care as a result of the same accident, only one Emergency care Copayment/Deductible will apply.
   b. Emergencies Resulting in an Inpatient Admission. If the Member is admitted to a MHCN or MHCN Designated Facility directly from the emergency room, the Emergency care Copayment is waived.

4. **Transfer and Follow-up Care.** If a Member is hospitalized in a non-MHCN Facility or non-MHCN Designated Facility, ***GHO*** reserves the right to require transfer of the Member to a MHCN Facility ***or MHCN Designated Facility,*** , upon consultation between a MHCN Provider and the attending physician***.*** If the Member refuses to transfer to a MHCN Facility ***or MHCN Designated Facility***, and remains in the non-MHCN Facility or non-MHCN Designated Facility, all services received will be covered as set forth in the Allowances Schedule under the Community Provider section of Inpatient Hospital Services.

   Under the managed care option, follow-up care which is a direct result of the Emergency must be received from MHCN ***Providers***. Follow-up care for services received under the Community Provider option for the same condition or symptoms within forty-eight (48) hours following the initial outpatient Emergency care services shall be covered as set forth under Section XII.L.2.a. above. Thereafter, all follow-up care received from a Community Provider that is a direct result of the Emergency is covered subject to the annual Deductible and Coinsurance as shown in the Allowances Schedule.

Urgent Care (see Section I. for a definition of Urgent Condition):

Under the managed care option, care for Urgent Conditions received inside the MHCN Service Area is covered only at MHCN medical centers, MHCN urgent care clinics, or network providers' offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a MHCN Provider.

Under the Community Provider option, care for Urgent Conditions is covered subject to the applicable coinsurance when GHO criteria is met.

M. AMBULANCE SERVICES

Ambulance services under the managed care option are covered provided that the service is authorized in advance by a MHCN Provider or meets the definition of an Emergency (see Section I.).

1. **Emergency Transport to any Facility.** Each Emergency is covered as set forth in the Allowances Schedule.

2. **Transfers.**

   a. **MHCN-Initiated Transfers.** Non-emergent MHCN-initiated transfers to or from a MHCN Facility or MHCN Designated Facility are covered.
   b. **Community Provider Transfers.** Transport from a medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered as set forth in the Allowances Schedule when prescribed by the attending physician.

N. SKILLED NURSING FACILITY care in an GHO-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, as set forth in the Allowances Schedule.

When prescribed by the Member's physician, such care may include board and room; general nursing care; drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term physical therapy, occupational therapy, and restorative speech therapy.

Excluded from coverage are personal comfort items such as telephone and television; and rest cures, custodial, domiciliary or convalescent care.

Section XIII. Exclusions

The Exclusions in this Section XIII. apply to those Members who receive services from (1) a MHCN Provider or are Referred by a MHCN Primary Care Provider under the managed care option, or (2) Community Providers on a self-referred basis under the Community Provider option under Section XII. Schedule of Benefits.

In addition to exclusions listed in the previous Sections, the following are excluded:

1. Except as specifically listed and identified as covered in Sections XII.B., XII.D., XII.H., and XII.J., corrective appliances and artificial aids including: eyeglasses; contact lenses, including services related to their fitting; hearing ***devices, hearing*** aids and examinations in connection therewith; take-home dressings and supplies following hospitalization; or any other supplies, dressings, appliances, devices or services which are not specifically listed as covered in Section XII.

2. Cosmetic services, including treatment for complications of cosmetic surgery, except as provided in Section XII.D.

3. Dental care, surgery, services, and appliances, including treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery, or any other dental service not specifically listed as covered in Section XII. Under the managed care option, the ***GHO's*** Medical Director, or his/her designee, will determine whether the care or treatment required is within the category of dental care or service. Under the Community provider option, GHO will determine whether the care or treatment required is within the category of dental care or service.

4. Drugs, medicines, and injections, except as set forth in Section XII.J. Any exclusion of drugs, medicines, and injections [including those not listed as covered in the ***GHO*** Drug Formulary (approved drug list) under the managed care option], also excludes their administration.

5. Convalescent or custodial care.

6. Durable medical equipment such as hospital beds, wheelchairs, and walk-aids, except while in the hospital, unless otherwise noted as covered in Section XII.

7. Services rendered as a result of work-***related*** injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment, unless otherwise noted in Section XII.B.

8. Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel or insurance purposes**.**

9. Experimental or investigational services.

   (a) A service is experimental or investigational for a Member's condition if any of the following statements apply to it as of the time the service is or will be provided to the Member. The service (i) cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or (ii) is the subject of a current new drug or new device application on file with the FDA; or (iii) is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or (iv) is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or (v) is under continued scientific testing and research concerning the safety, toxicity, or efficacy of services; or (vi) is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy; or As to the service: (vii) the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.

   (b) In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively: (i) the Member's medical records, (ii) the written protocol(s) or other document(s) pursuant to which the service has been or will be provided, (iii) any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service, (iv) the files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body, (v) the published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and (vi) regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

   (c) GHO consults with GHO's Medical Director and then uses the criteria described above to decide if a particular service is experimental or investigational.

   Appeals regarding denial of coverage must be submitted to MHCN's regional Member Services (under the managed care option), or to GHO's Medical Director at PO BOX 34588, Seattle, WA 98124-1588. GHO will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if delay would jeopardize the Member's life or health.

10. Procedures and services to reverse a therapeutic or nontherapeutic sterilization.

11. Mental health care, except as specifically provided in Section XII.K.

12. Services and supplies related to ***sexual reassignment surgery, such as sex change operations or*** transformations ***and procedures or treatments designed to alter physical characteristics***.

13. Regardless of origin or cause, diagnostic testing and medical treatment of sterility, infertility, and sexual dysfunction, unless otherwise noted as covered in Section XII.B.

14. Any services to the extent benefits are available to the Member under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, whether the Member asserts a claim or not, pursuant to: (1) medical coverage, medical "no fault" coverage, Personal Injury Protection coverage, or similar medical coverage contained in said policy; and/or (2) uninsured motorist or underinsured motorist coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member is a named insured, comes within the policy definition of insured, is a third-party donee beneficiary under the terms of the policy, or otherwise has the right to receive benefits under the policy.

    The Member and his or her agents must cooperate fully with GHO in its efforts to enforce this exclusion. This cooperation shall include supplying GHO with information about any available insurance coverage. The Member and his or her agent shall permit GHO, at GHO's option to associate with the Member or to intervene in any action filed against any party related to the injury. The Member and his or her agents shall do nothing to prejudice GHO's right to enforce this exclusion. ***In the event the Member fails to cooperate fully, the Member shall be responsible for reimbursing GHO for such medical expenses.***

GHO shall not enforce this exclusion as to coverage available under uninsured motorist or under insured motorist coverage until the Member has been made whole, unless the Member fails to cooperate fully with GHO as described above.

GHO shall not pay any attorneys' fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHO prior to any collection efforts. ***Under no circumstances will GHO pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHO. If it becomes necessary for GHO to enforce the provisions of this section by initiating any action against the injured person or his or her agent, then the injured person agrees to pay GHO's attorneys' fees and costs associated with the action.***

15. Services and items not specifically listed as covered in this Schedule of Benefits.

16. The cost of services and supplies resulting from a Member's loss of or willful damage to covered appliances, devices, supplies, and materials for the treatment of disease, injury, or illness.

17. Orthoptic (eye training) therapy.

18. Specialty treatment programs as defined by GHO, such as weight reduction, rehabilitation ***(including cardiac rehabilitation)***, and "behavior modification programs."

19. Services and items that are not Medically Necessary as determined by GHO.

20. Services required as a result of war, whether declared or not declared. Care needed for injuries or conditions resulting from active or reserve military service.

21. Autopsy, except when requested by the MHCN Provider or GHO.

22. Hypnotherapy, and all services related to hypnotherapy.

23. Services of unlicensed practitioners.

24. Genetic testing and related services are excluded unless determined Medically Necessary by GHO ***in accordance with Board of Health standards for screening and diagnostic tests***, or specifically provided in Section XII.B. Testing for non-Members is also excluded.

25. Follow-up visits related to a non-Covered Service.

26. Routine ultrasound to determine fetal age, size or sex.

27. Missed appointment or cancellation fees.

28. Routine foot care except in the presence of a non-related Medical Condition affecting the lower limbs.

29. Complications of non-Covered Services.

30. Treatment of obesity, except as set forth in Section XII.B.

CA-416a01
CA-1943
CA-1825
CA-141302 (PEC-0)
CA-55002 (OT-L)
CA-1774 (AS-A)
DA-504a01 - (HA-B)
CA-1775 (DS-J)
CA-140302 (DE-A)
CA-75702 (PR-A)
CA-1766 – (RX-FK)